

## Section 2: Prevention Needs, Resources and Gaps

---

A central part of the development of this HIV Prevention Plan for the District of Columbia was the development of a Needs Assessment, Resource Inventory and Gap Analysis that would help guide the HIV Prevention Community Planning Group (HPCPG) in determining what population groups should be prioritized to receive HIV prevention services in 2003 and 2004.

The Assessment attempts to determine the HIV prevention needs of the populations identified by the epidemiologic profile as being at high risk for HIV infection, as well as other population groups identified by the HPCPG and the HIV/AIDS Administration. The Resource Inventory assessed existing community resources for HIV prevention to determine the community's capacity to respond to the epidemic. The Gap Analysis attempts to identify the met and unmet HIV prevention needs within these populations, by comparing the populations' needs and the resources available for that population.

All residents of the District of Columbia need to be informed about HIV and provided with assistance to obtain the knowledge, skills and motivation needed to protect themselves and others from infection with HIV.

In 1992, the District's Commission of Public Health (CPH) conducted a telephone survey of DC residents aged 18-45 and found that, although the number of persons with multiple sex partners who reported always using condoms was higher than in a national sample, condom use was still not widespread, according to a report from the Centers for Disease Control and Prevention (CDC) in the *Morbidity and Mortality Weekly Report* (05/28/93) Vol. 42, No. 20, P. 390. The questions asked addressed HIV-related knowledge, number of sex partners, and condom use during the year preceding the survey. The survey found that 25% of respondents reported having had two or more sex partners during the previous 12 months.

Those who were not in a steady relationship accounted for 55% of the respondent population and those who self-rated their HIV risk as "high" or "medium" comprised 55% and were more inclined to report multiple partners. Men were found to be more likely than women (35% versus 15%) and blacks were more likely than whites (28% versus 20%) to report having had two or more partners. About 40% of respondents reported always using condoms, and 34% reported never using condoms.

Of those sexually active persons not in a steady relationship, 65% reported always using condoms, and 11% reported never using condoms. Among those who reported having had two or more sex partners, 59% reported always using condoms, and 9% reported never using condoms. Also, 70% of men who had two or more sex partners reported always using condoms, compared with 37% of women.

The CDC's AIDS Surveillance Report for the period ending June 2001 states that adult/adolescent males in the District had an annual rate of AIDS of 299.9 cases per 100,000 population for cases reported July 2000 through June 2001, compared with a national rate for males of 27.2 cases per 100,000 population. The rate for adult/adolescent females in the District was 102.1 per 100,000 population for the same period, compared with the national rate for women of 8.4 cases of AIDS per 100,000 population.

Financial constraints affect the extent and intensity of primary HIV prevention efforts funded by the HIV/AIDS Administration. As a result, the HIV Prevention Community Planning Group must focus attention on those populations that are at highest risk for infection. This section attempts to provide a description of the HIV prevention needs of several population groups and the barriers in reaching those populations, to help the HPCPG identify those most in need of prevention services and the best possible interventions for them.

Although this document identifies at-risk individuals by groups such as age, gender, sexual orientation and race/ethnicity, it should be clear that those factors do not place individuals at risk of

infection with HIV. It is their behavior that may increase their risk, and it is those behaviors – and the causes for those behaviors – that are the intended focus of all prevention efforts.

Various sources of information were used for this section, including new information from behavioral surveys, focus groups and community consultations conducted in the District of Columbia over the past three years. Since 1999, various organizations have conducted behavioral studies on transgendered individuals, white gay and bisexual men, Black heterosexual men and women, male commercial sex workers, women who use crack or inject drugs, and HIV-positive men that inject drugs. Smaller surveys and focus groups have been conducted with Asian and Pacific Islander, Black and Latino men who have sex with men.

Because relatively few studies have been done in the District on several of the populations described below, a significant amount of information comes from studies done elsewhere. Most of the information is supported by research, but some is anecdotal, based on the experiences of providers and consumers.

In viewing these materials, readers should be aware that the experiences described in studies done in California, New York or elsewhere may not generalize to other major U.S. cities, including the District of Columbia. Similarly, the risk behavior and other information gathered from participants in the various focus groups held in the District of Columbia may not generalize for other members of those populations.

The development and implementation of effective strategies to ensure that prevention initiatives address the needs of these special populations is a critical component to the District's overall HIV prevention effort. A description of those interventions can be found in Section 3: Potential Strategies and Interventions.

This section of the plan discusses the specific prevention needs of population groups in the District of Columbia, providing information on the status, risk behaviors, barriers and needs of populations engaging in high-risk behaviors associated with the transmission of HIV.

## DATA

---

The following data and information is provided, when available, for each of the populations:

**Size of the population:** A variety of sources were used to provide estimates for each of the populations. Data on various racial and ethnic populations by gender or age are taken or extrapolated from the 2000 US Census. Populations that are defined by other factors and circumstances are estimates based on various studies, and are referenced where appropriate.

**AIDS incidence and rate for the Period 1996 – 2001:** This section reports the number of new cases reported in those five years, and the rate of new cases per 10,000 population for those five years. While the proportion of AIDS cases reflects which populations are most represented among persons living with AIDS, the rate reflects the relative impact on the population for its size. Incidence rates are most useful when comparing across populations. The following provides an example of how the incidence rate is determined.

**Example:**

If the number of new AIDS cases reported for a population was 75 cases in 1996-2001, and the size of the population was estimated at 50,000, then the incidence rate would be calculated as 75 divided by 50,000 and multiplied by 10,000. The AIDS incidence rate would be 15 per 10,000 population.

The information in the section on “AIDS Incidence” only includes reported AIDS cases. There may be a considerable length of time – 10 years or longer – from HIV infection until an individual’s health status meets the criteria for being diagnosed with AIDS, particularly with the increasing use of antiretroviral medications since 1995. Thus, AIDS cases do not necessarily reflect the characteristics of persons with more recently acquired HIV infection. HIV seroprevalence, which refers to the prevalence of HIV infection among the population, is not available at this time, although the District began surveillance of HIV infection at the end of 2001.

**General Characteristics of the Population.** This section provides some general socio-demographic descriptors of the population.

**Risk Assessment.** This section contains a discussion of findings from formal and informal studies on the risk behaviors of the population. Where available, it includes data reported from behavioral studies, as well as from focus groups with members of the population, service providers and/or key informants with special knowledge of the population. The section reports what is known about the riskiness of behaviors among each group, the prevalence of risk behaviors, and about multiple risk factors.

**Riskiness of Behavior:** Different sexual activities affect the odds that someone will get infected with HIV. In a study published in the January 2002 issue of the Journal of Sexually Transmitted Diseases, researchers at the Centers for Disease Control and Prevention said that performing unprotected oral sex is twice as risky as receiving oral sex. When compared to receiving oral sex, unprotected insertive vaginal sex is 10 times riskier, insertive anal sex 13 times more dangerous, receptive vaginal sex 20 times more hazardous, and unprotected receptive anal sex 100 times more perilous.

### CDC Comparison of Risk by Behavior

Behavior	Risk
Receiving Oral Sex (ROS)	Baseline: 1
Performing Oral Sex	2 times higher than ROS
Insertive Vaginal Sex	10 times higher than ROS
Insertive Anal Sex	13 times higher than ROS
Receptive Vaginal Sex	20 times higher than ROS
Receptive Anal Sex	100 times higher than ROS

In 1997, the San Francisco HIV Prevention Planning Group (PPG) reviewed studies from and interviewed researchers in San Francisco, New Jersey and Italy, and an article in the British Medical Journal. Based on this review the PPG estimated the relative risk of several behaviors as follows:

Risk Behavior / Act	Relative Risk
Male receiving unprotected oral sex	0.1
Performing oral sex on a male	1
Female receiving unprotected cunnilingus (oral sex)	0.1
Performing oral sex on a female	0.5
Unprotected insertive vaginal intercourse	1.5
Unprotected vaginal receptive intercourse	3
Unprotected insertive anal intercourse	2
Unprotected anal receptive intercourse	9
Sharing unsterile needles	12

**Prevalence of Risk Behaviors:** This section reports on what is known about the prevalence of risk behaviors in each of the specific populations. There is little information available on the prevalence of risky behavior among different populations in the District. The San Francisco PPG gathered information from a review of 30 studies and "best-guess" estimates by PPG members to determine the average number of times that population groups engaged in risky behaviors annually. The following table shows how the San Francisco PPG estimated the annual frequency of risky behavior by population groups.

Population groups and behavior	Estimated annual frequency of behavior
<b>Injecting drug users</b>	
Sharing unclean needles	39
<b>Gay/Bisexual Men</b>	
Unprotected receptive anal intercourse	21
Unprotected insertive anal intercourse	21
Receiving fellatio, unprotected	37
Giving fellatio, unprotected	9
<b>Heterosexual Men</b>	
Unprotected insertive vaginal intercourse	82
Unprotected insertive anal intercourse	6
Receiving fellatio, unprotected	42
Giving cunilingus, unprotected	41
<b>Heterosexual Women</b>	
Unprotected receptive vaginal intercourse	77
Unprotected receptive anal intercourse	6
Giving fellatio, unprotected	48
Receiving cunilingus, unprotected	35

**Multiple Risk Factors:** In most cases, this section presents a summary of risk behaviors for each population that are described earlier in the risk assessment section. These may be findings from formal and informal studies on the risk behaviors of the population, or the opinion of HIV prevention providers about the populations they serve.

**Challenges and Obstacles to Prevention (Difficulty Meeting Need).** This section focuses on issues and conditions that may negatively affect the provision of prevention services for the population. These impediments may be related to special characteristics of the population as well as factors reflecting inadequacies in the systems that provide services to the population.

**Recurring and Emerging Issues.** This section highlights themes that are either consistent over time or have recently surfaced as notable trends or potential concerns. The section also may include noteworthy prevention and intervention strategies.

**Resources and Gaps.** This section includes information on the number of HIV prevention programs targeting each population in 2002, as well as the number of individuals that will be reached by those programs. The reader should be aware that the targets include some duplicate numbers, because outreach interventions usually encounter the same individuals two or more times over a year. This

section also identifies the HIV prevention interventions that have been shown to be effective for each population and what interventions are being implemented for that population in 2002.

**Need for Additional Studies.** This section lists areas in which more information is needed in order to more fully understand the prevention needs of the population.

**Sources of Data.** Contains a list of data sources for each respective population report.

## **Contents of this Section**

<b>Summary of Population Sizes and AIDS Rates.....</b>	<b>Page 2.8</b>
<b>Adolescents and Young Adults .....</b>	<b>Page 2.12</b>
<b>Black/African American Heterosexual Females .....</b>	<b>Page 2.18</b>
<b>Black/African American Heterosexual Males .....</b>	<b>Page 2.23</b>
<b>Blind and Physically Disabled.....</b>	<b>Page 2.27</b>
<b>Commercial Sex Workers .....</b>	<b>Page 2.29</b>
<b>Deaf and Hard of Hearing.....</b>	<b>Page 2.34</b>
<b>Homeless .....</b>	<b>Page 2.37</b>
<b>Immigrants .....</b>	<b>Page 2.41</b>
<b>Incarcerated, Re-entry Prisoners and Ex Offenders .....</b>	<b>Page 2.43</b>
<b>Injecting Drug Users (IDU).....</b>	<b>Page 2.46</b>
<b>Latino Heterosexuals .....</b>	<b>Page 2.52</b>
<b>Latina Heterosexual Females .....</b>	<b>Page 2.53</b>
<b>Latino Heterosexual Males .....</b>	<b>Page 2.57</b>
<b>Men Who Have Sex with Men (MSM).....</b>	<b>Page 2.61</b>
<b>Asian/Pacific Islander MSM.....</b>	<b>Page 2.62</b>
<b>Black/African American MSM .....</b>	<b>Page 2.65</b>
<b>Latino MSM.....</b>	<b>Page 2.69</b>
<b>White MSM.....</b>	<b>Page 2.74</b>
<b>MSM who are also Injecting drug users.....</b>	<b>Page 2.77</b>
<b>Mentally Ill / Individuals with Persistent Mental Illness.....</b>	<b>Page 2.80</b>
<b>Older Adults (Persons 50 years and older) .....</b>	<b>Page 2.85</b>
<b>People Living with HIV/AIDS .....</b>	<b>Page 2.88</b>
<b>Pregnant Women with or at risk for HIV.....</b>	<b>Page 2.93</b>
<b>Substance Users.....</b>	<b>Page 2.95</b>
<b>Transgendered Individuals .....</b>	<b>Page 2.99</b>

## Summary of Population Sizes and AIDS Rates

Population	Size of Population	% of population within each group / population	AIDS Incidence: New Cases in 1996-2001 (1)	Rate per 10,000 population for 1996-2001 (1)	% of New Cases within each group / population	% Change in new AIDS cases: 1995 vs. 2000 (1)
<b>Injecting Drug Users (IDUs) 18 to 54 (2)</b>						
<b>Black / African American</b>	5,832	53.6%	1,386	78	95.8%	-58.0%
<i>Male</i>			885		61.2%	-63.3%
<i>Female</i>			501		34.6%	-44.4%
<b>White</b>	2,994	33.7%	45	4	3.1%	-53.8%
<i>Male</i>			28		1.9%	-25.0%
<i>Female</i>			17		1.2%	-
<b>Latino/Hispanic</b>	768	8.9%	16	5	1.1%	66.7%
<i>Male</i>			12		0.8%	33.3%
<i>Female</i>			5		0.3%	-
<b>Other</b>	262	3.8%		-	-	-
<i>Male</i>				-	-	-
<i>Female</i>				-	-	-
<b>Total</b>	<b>9,856</b>		<b>1,447</b>	<b>44</b>	<b>100%</b>	<b>-56.9%</b>
<b>Gay / Bisexual Men (3)</b>						
<b>Blacks/African Americans</b>	11,365	51.2%	1,158	142	69.1%	-58.9%
<b>Whites</b>	5,682	35.4%	415	55	24.8%	-69.7%
<b>Latinos / Hispanics</b>	1,496	10.2%	89	74	5.3%	-61.9%
<b>Asians &amp; Pacific Islanders</b>	398	3.2%	14	28	0.8%	-
<b>Total</b>	<b>18,941</b>	<b>100%</b>	<b>1,676</b>	<b>105</b>	<b>100%</b>	<b>-62.5%</b>
<b>Heterosexuals, 18-65 * (4)</b>						
<b>Black / African American</b>	178,225	53.6%	926	52	92.4%	-22.2%
<i>Male</i>	81,600	24.6%	386	47	38.5%	-9.1%
<i>Female</i>	96,625	29.1%	540	56	53.9%	-30.0%
<b>White</b>	111,988	33.7%	29	3	2.9%	-16.7%
<i>Male</i>	56,379	17.0%	11	2	1.1%	-
<i>Female</i>	55,609	16.7%	18	3	1.8%	-
<b>Latino/Hispanic</b>	29,475	8.9%	45	15	4.5%	25.0%
<i>Male</i>	16,254	4.9%	26	16	2.6%	0.0%



Population	Size of Population	% of population within each group / population	AIDS Incidence: New Cases in 1996-2001 (1)	Rate per 10,000 population for 1996-2001 (1)	% of New Cases within each group / population	% Change in new AIDS cases: 1995 vs. 2000 (1)
<i>Female</i>	13,221	4.0%	19	14	1.9%	50.0%
<b>Other</b>	12,687	3.8%	-	-	0.2%	-
<i>Male</i>	5,651	1.7%	-	-	-	-
<i>Female</i>	7,036	2.1%	-	-	-	-
<b>Total</b>	<b>332,375</b>	<b>100%</b>	<b>1,002</b>	<b>30</b>	<b>100%</b>	<b>-20.8%</b>
<b>Adolescents and Young Adults, 13 to 24 (4)</b>						
<b>Black / African American</b>	55,767	55.3%	158	28	86.3%	-57.9%
<i>Male</i>	26,237	26.0%	79	30	43.2%	-53.3%
<i>Female</i>	29,530	29.3%	79	27	43.2%	-60.9%
<b>Latino/Hispanic</b>	9,921	9.8%	13	13	7.1%	50.0%
<i>Male</i>	5,400	5.4%	10	19	5.5%	100%
<i>Female</i>	4,521	4.5%	-	-	-	0.0%
<b>Asian/Pacific Islander</b>	3,755	3.7%	-	-	-	-
<i>Male</i>	1,633	1.6%	-	-	-	-
<i>Female</i>	2,122	2.1%	-	-	-	-
<b>White</b>	30,523	30.3%	9	3	4.9%	-50.0%
<i>Male</i>	13,702	13.6%	6	4	3.3%	-66.7%
<i>Female</i>	16,821	16.7%	-	-	-	0.0%
<b>Other Races Combined</b>	925	0.9%	-	-	-	-
<i>All other male</i>	436	0.4%	-	-	-	-
<i>All other female</i>	489	0.5%	7	143	3.8%	-
<b>Youth Total Male</b>	46,972	46.6%	97	21	53.0%	-47.4%
<b>Youth Total Female</b>	52,994	52.5%	86	16	47.0%	-56.0%
<b>Total</b>	<b>100,891</b>	<b>100%</b>	<b>183</b>	<b>18</b>	<b>100%</b>	<b>-52.3%</b>
<b>Older Adults, 55 and older (4)</b>						
<b>Black / African American</b>	78,787	40.4%	472	60	82.8%	-26.5%
<i>Male</i>	30,712	15.8%	368	120	64.6%	-26.2%
<i>Female</i>	48,075	24.7%	104	22	18.2%	-27.8%
<b>Latino/Hispanic</b>	4,050	2.1%	23	57	4.0%	-50.0%
<i>Male</i>	1,548	0.8%	21	136	3.7%	-50.0%

Population	Size of Population	% of population within each group / population	AIDS Incidence: New Cases in 1996-2001 (1)	Rate per 10,000 population for 1996-2001 (1)	% of New Cases within each group / population	% Change in new AIDS cases: 1995 vs. 2000 (1)
<i>Female</i>	2,502	1.3%	-	-	-	-
<b>Asian/Pacific Islander</b>	2,037	1.0%	-	-	-	-
<i>Male</i>	828	0.4%	-	-	-	-
<i>Female</i>	1,209	0.6%	-	-	-	-
<b>White</b>	33,495	17.2%	71	21	12.5%	-44.4%
<i>Male</i>	15,625	8.0%	67	43	11.8%	-50.0%
<i>Female</i>	17,870	9.2%	-	-	-	-
<b>Total</b>	<b>118,369</b>		<b>570</b>	<b>48</b>		<b>-29.4%</b>
<b>Other Population Groups</b>						
People Living with HIV/AIDS (5)	19,418 – 21,418					
Pregnant Women (6)	10,679					
Transgendered Persons	Unknown					
Incarcerated (7)	10,150		256	252		-74.3%
Immigrants (8)	73,561					
Homeless adults (9)	5,750		295	395		-38.3%
Commercial Sex Workers	Unknown					
Mentally Ill, age 18 and over (10)	26,250 (Range 18, 123 – 34,776)					
Deaf/Hard of Hearing (11)	24,026					
Blind/physically disabled (12)	40,047					

\* For surveillance purposes, the CDC classifies heterosexual contact as sex with a person that has a history of injecting drug use, a person living with HIV/AIDS, a person who has received a blood transfusion or blood products, or sex with a bisexual male (for females only).

#### Data Sources for Population Sizes

- (1) 2002 Epidemiologic Profile of the District of Columbia
- (2) Report from the Addiction, Prevention and Recovery Administration, 2001

- (3) Estimates based on a formula proposed by Scott D. Holmberg, MD, MPH in The Estimated Prevalence and Incidence of HIV in 96 Large US Metropolitan Areas, in combination with the 2000 US Census Bureau report of population sizes for the District of Columbia.
- (4) 2000 U.S. Census
- (5) 2002 Epidemiologic Profile of the District of Columbia. Includes 7,418 living with AIDS.
- (6) Estimate based on a report from the District's State Center for Health Statistics on the number of pregnancies in the District in 1998
- (7) D.C. Department of Corrections
- (8) Washington Metropolitan Council of Governments
- (9) "Homeless Enumeration for the Washington Metropolitan Region 2002," prepared by the Homeless Services Planning and Coordinating Committee of the Washington Metropolitan Council of Governments. May 2002.
- (10) Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 1990 estimate of the number of persons with serious mental illness by State. The estimate does not include persons who are homeless or institutionalized.
- (11) According to the US census, Bureau (1997) 3.8% of Americans over the age of 15 have difficulty hearing and 0.4% are unable to hear. Applying national estimates, there would be 24,026 deaf and hard of hearing persons living in the District. US Census Bureau (2001) Americans With Disabilities, Household Economic Studies, 1997 Population Reports
- (12) 1990 US Census

<b>Population</b>	<b>Adolescents and Young Adults (13 - 24)</b>
<b>Size of Population</b>	<p>100,891</p> <p>2000 US Census</p>
<b>AIDS Incidence: 1996-2001</b>	<p>New AIDS Cases: 183</p> <p>AIDS Rate: 18 per 10,000 population</p>
<b>Risk Assessment</b>	<p>Of the 345 AIDS cases reported in the District among males 13 to 24 from 1980 through 2001, 69% were among MSM and 6.1% among MSM/IDUs. Heterosexual contact was the risk factor for 12.8% of the cases, and IDU was the risk behavior for 6.7% of the cases. (1)</p> <p>Among females in the same age range, 72% of the cases were attributed to heterosexual contact. Injecting drug use accounted for 17.4% of the cases.</p> <p>For surveillance purposes, the CDC classifies heterosexual contact as sex with a person that has a history of injecting drug use, a person living with HIV/AIDS, a person who has received a blood transfusion or blood products, or sex with a bisexual male (for females only).</p> <p>Half of all new infections in the U.S. occur in people younger than 25. From 1994 to 1997, 44% of all HIV infections among young people aged 13-24 occurred among females, and 63% among African-Americans. While the number of new AIDS cases is declining among all age groups, there has not been a comparable decline in the number of new HIV infections among young people in the U.S. (2)</p> <p>Some sexually active young African-American and Latina women are at especially high risk for HIV infection, especially those from poorer neighborhoods. A study of disadvantaged out-of-school youth in the US Job Corps found that young African-American women had the highest rate of HIV infection, and that women 16-18 years old had 50% higher rates of infection than young men. (3) Another study of African-American and Latina adolescent females found that young women with older boyfriends (3 years older or more) are at higher risk for HIV. (4)</p> <p>A recent national survey of teens in school showed that from 1991 to 1997 the prevalence of sexually activity decreased 15% for male students, 13% for White students and 11% for African-American students. However, sexual experience among female students and Latino students did not decrease. Condom use increased 23% among sexually active students. However, only 43% of sexually active students did not use condoms during their last sexual intercourse. (5)</p> <p>Among Latino youth, the lack of parental discussions and education regarding sex and condoms seems to contribute to the disproportionate number of unintended pregnancies, sexually transmitted diseases and HIV cases among Latino youth. (12)</p>

### ***In the District of Columbia***

The Youth Risk Behavior Survey (YRBS) conducted by D.C. Public Schools in middle schools (grades 6 to 8) and high schools (grades 9 to 12) offers some insight into the sexual activity of youth in the District. (6)

Among high school students surveyed in grades nine through twelve, 71.7% of males and 53.5% of females reported that they had experienced sexual intercourse, and 29.9% of males and 18.8% of females had engaged in sexual intercourse with four or more people during their life. A substantial proportion of youth, 41.4%, had sexual intercourse with one or more people in the three months before the survey. Among these sexually active youth, condom use was higher among males (82.2%) than among females (64.8%).

More than one in four middle school youth, 29.2%, had experienced sexual intercourse: 38.8% of males and 20.2% of females. Among males, 17.6% reported they had sexual intercourse for the first time before age 11, as did 5.6% of females, and 17% of males and 5.8% of females reported that they had engaged in sexual intercourse with three or more people during their life. Of the sexually experienced youth, 79.7% reported the use of a condom during their last sexual intercourse. Condom use rates were the same for males and females.

Of all the middle and high school students that engaged in sexual relations in the three months prior to the survey, 21% reported that they had not used a condom, compared with 25.8% in the previous survey, done in 1999. In 1997, 32.1% said they had not used a condom and in 1993 35% reported they had not used a condom the last time they had sexual relations.

One in five High School students reported marijuana use in the past 30 days and 28 % reported that they had at least one drink of alcohol on one or more of the past 30 days. Much smaller proportions reported other drug use in the past 30 days, such as cocaine in any form, powder, crack or freebase (2.8 %); glue sniffing, inhaling paints, sprays and the like (3.0%); or injecting drug use one or more times during their life (3.2 %).

Forty one percent of younger middle-schoolers reported that had consumed a drink of alcohol beyond a few sips and 16.9% used marijuana at least once during their lifetime. Among middle school youth, 7.1% admitted to cocaine use (e.g. powder, crack or freebase) at least once in their life, 15.6% said they had sniffed glue, or inhaled paints or sprays, and 6.4% reported using a needle to inject an illegal drug into their body at least once in their life.

According to the 2000 Household Survey on Substance Abuse conducted by the Addiction, Prevention and Recovery Administration (7):

- Alcohol and marijuana appear to be the drugs most widely used by youth and young adults.
- About one of every six adolescent (12 - 17 years) reported using an alcoholic beverage in the last 30 days.

- Prevalence of alcohol use was highest among young adults between 18 - 24 years.
- Young adults between the ages 18 - 24 years were more likely than others to report using an illicit drug within the past year and within the past month.
- Young adults 18 - 24 reported higher past and current usage of marijuana.
- Black youth reported higher rates of current marijuana use (9%) than white youth (4.5%) and Hispanic/Latino youth (2%).
- Of persons needing treatment for substance use, 2% (837) were between the 12 - 17 years of age and 25% (9,400) were between the ages 18 - 24 years.

A study conducted in the District in 1997 by the D.C. Community Prevention Partnership, among girls 9 to 15 years old, found that drug use is considered acceptable behavior among some African-American girls. The drugs and substances of choice were marijuana, cigarettes, alcohol and crack cocaine and many girls did not recognize the risks and negative consequences of drug and substance use and abuse.

Not all adolescents are equally at risk for HIV infection. Teens are not a homogenous group, and various subgroups of teens participate in higher rates of unprotected sexual activity and substance use, making them especially vulnerable to HIV and other STDs. Nationally, these include teens who are gay/exploring same-sex relationships, drug users, juvenile offenders, school dropouts, runaways, homeless and migrant youth. These youth are often hard to reach for prevention and education efforts since they may not attend school on a regular basis and have limited access to health care and service-delivery systems. (8)

Youth who are not in school have higher frequencies of behaviors that put them at risk for HIV/STDs, and are less accessible by prevention efforts. A national survey of youth aged 12-19 found that 9% were out-of-school. Out-of-school youth were significantly more likely than in-school youth to have had sexual intercourse, had four or more sex partners, and used alcohol, marijuana and cocaine. (9)

The District of Columbia has the highest school dropout rate in the nation for grades 9-12, according to the National Center for Education Statistics of the U.S. Department of Education. In the 1997-1998 school year, 12.8% of students in those grades dropped out DC schools

### **Young Males who have Sex with Males**

A study by the Centers for Disease Control and Prevention found that young gay men in the United States are more likely to practice unsafe sex and contract HIV as compared to their older counterparts. The study, presented by Dr. Gordon Mansergh at the 12th World AIDS Conference in Geneva, investigated sexual habits among HIV-negative gay and bisexual men in Denver, Chicago and San Francisco. Almost two-thirds

of the gay men reported that they had engaged in unprotected anal sex in the previous 18 months and 56% of gay men aged less than 25 years said that they had engaged in unprotected receptive anal intercourse in the same time frame.

Comparatively, 46% of older gay men reported that they had engaged in the same risky activity in the prior 18 months. The study found that the increased risk habits are associated with perceived peer norms concerning unprotected anal sex. Additionally, young gay men who socialize and meet partners in bars were more likely to have unprotected sex. The researchers suggested that prevention efforts focus on changing peer norms and reaching young men in bar settings.

Most young gay men in the U.S. are unaware they are infected with HIV, according to a report presented by Duncan MacKeller, an epidemiologist with the Centers for Disease Control and Prevention, during the 2002 International AIDS Conference in Barcelona.

Of 5,719 young gay men tested in several American cities – Baltimore, Dallas, Los Angeles, New York and Seattle – 573 or about 10% tested positive for HIV. Of those 573 infected individuals, 440 men, or 77%, did not know that they were infected.

MacKeller said that, broken down by ethnic group, 91% of gay or bisexual African-American men did not know if they were infected with HIV, 70% of gay or bisexual Latinos were unaware of their HIV status, and 60% of gay or bisexual whites did not know whether they had the disease.

#### **Observations from participants in the Community Consultations held by the HPCPG:**

Reasons why youth engage in high risk sexual practices

- **Economic survival** – For many young people, “survival” sex is the only opportunity for them to earn the amount of money they need and/or want. Young women and young men pair up with older men for financial support, reinforcement to their sexuality, and some stability in their lives. According to the US census, more than one fourth of the families with children fewer than 18 years age live in poverty.

- **Coping with stress** – Some youth desire an altered state of mind to avoid the circumstances of their existence – poverty, violence, abuse, isolation. Lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth have added concerns about how their sexual identity is perceived by others.

One of the venues in which high-risk behaviors occur is “skipping parties,” during which youth “skip” and participate in parties in private homes where they use alcohol and a variety of drugs, and there are frequent sexual encounters in the open and in private rooms. Skipping parties were reported during the community consultations held for youth as well as the immigrant consultation.

**Riskiness of Behavior:** The CDC has estimated that the risk of insertive

	<p>vaginal sex is 10 times riskier than receiving oral sex (ROS) and that insertive anal sex is 13 times riskier than ROS. Unprotected insertive anal sex is 13 times higher than receiving oral sex (ROS), unprotected receptive anal sex is 100 times riskier than ROS, and the risk of performing unprotected oral sex is two times higher than ROS</p> <p><b><u>Prevalence of Risk Behaviors:</u></b> There are no studies on the prevalence of risk behavior among adolescents and young adults in the District.</p>
<b>Challenges and Obstacles to Prevention (Difficulty Meeting need)</b>	Nationally, HIV prevention programs typically do not target out-of-school youth, and programs for other youth typically address heterosexual relationships and don't deal with the issues of LGBTQ youth. Thus, young MSM, homeless youth and incarcerated youth are groups that might be missed by HIV prevention efforts for youth. (11)
<b>Recurring and Emerging Issues</b>	A community consultation that focused on the issues of adolescents and young adults noted a major comeback of the drug PCP in both the inner city and the surrounding suburban communities.
<b>Resources and Gaps</b>	<p>The Resource Inventory identified 11 HIV prevention programs for adolescents and young adults, including three programs that target young gay/bisexual men, one program that targets young transgendered individuals, two programs that target young Latinos, and one program that targets young Asians and Pacific Islander MSM, with a collective capacity of reaching some 16,00 individuals, out an estimated population of 101,690.</p> <p>Several studies have found that group-level interventions, outreach, individual-level interventions, and programs aimed at changing community norms have been effective in reducing HIV risk behavior among youth. Studies with young gay/bisexual men have shown that outreach, group-level interventions and community mobilization are effective interventions for that population.</p> <p>The organizations serving youth and young adults in the District provide individual counseling, group level intervention, prevention case management and outreach interventions</p>
<b>Sources of Data</b>	<ol style="list-style-type: none"> <li>1. HIV/AIDS Administration, Epidemiologic Profile of the District of Columbia, 2002.</li> <li>2. Centers for Disease Control and Prevention. Young people at risk-epidemic shifts further toward young women and minorities. Fact sheet prepared by the CDC. July 1998.</li> <li>3. Valleroy LA, MacKellar DA, Karon JM, et al. HIV infection in disadvantaged out-of-school youth: prevalence for US Job Corps entrants, 1990 through 1996. Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology. 1998;19:67-73.</li> <li>4. Miller KS, Clark LF, Moore JS. Sexual initiation with older male partners and subsequent HIV risk behavior among female adolescents. Family Planning Perspectives. 1997;29:212-214.</li> <li>5. Centers for Disease Control and Prevention. Trends in sexual risk behaviors</li> </ol>



- among high school students-United States, 1991-1997. *Morbidity and Mortality Weekly Report*. 1998;47:749-752.
6. National Center for Chronic Disease Prevention and Health Promotion, National Youth Risk Behavior Survey (2001)
  7. Addiction Prevention and Recovery Administration (2001) 2000 Household Survey on Substance Abuse, Summary of Findings. District of Columbia, Department of Health.
  8. Rotheram-Borus MJ, Mahler KA, Rosario M. AIDS prevention with adolescents. *AIDS Education and Prevention*. 1995;7:320-336.
  9. Centers for Disease Control and Prevention. Health risk behaviors among adolescents who do and do not attend school-United States, 1992. *Morbidity and Mortality Weekly Report*. 1994;43:129-132.
  10. HPCPG Community Consultations on Youth and HIV/AIDS Prevention (April 25, 2002) and on Immigrants and HIV/AIDS Prevention (May 2, 2002)
  11. American Academy of Pediatrics, Committee on Pediatric AIDS. Adolescents and Human Immunodeficiency Virus Infection: The Role of the Pediatrician in Prevention and Intervention. *Pediatrics*. 2001; 107: 188-190. 9.
  12. The National Campaign to Prevent Teen Pregnancy. Whatever Happened to Childhood? The Problem of Teen Pregnancy in the United States. 1997.

<b>Population</b>	<b>Black / African American Heterosexual Females</b>
<b>Size of Population</b>	<p>96,625 (ages 18 – 65 years)</p> <p>Extrapolated from the 2000 US Census</p>
<b>AIDS Incidence: 1996 – 2001</b>	<p>New Cases of AIDS: 540</p> <p>AIDS Rate: 56 per 10,000 population</p>
<b>General Characteristics of the Population</b>	<p>The Black population in the District of Columbia consists primarily of African Americans born in the United States. However, a number of Black immigrants from various African countries and the Caribbean have chosen the District for their home. Blacks comprise 60% of the District's population.</p>
<b>Risk Assessment</b>	<p>There has been limited behavioral research on risk behavior by Black women in the District of Columbia. Among the AIDS cases reported among adult/adolescent Black women in 1996-2000 in the District, the risk factor for 42% of the cases was heterosexual contact, while 39% of the cases were attributed to injecting drug use. (1) (The CDC classifies heterosexual contact for women as sex with a person that has a history of injecting drug use, with a person living with HIV/AIDS, with a person who has received a blood transfusion/or blood product, or with a bisexual male.)</p> <p>For cases reported in the period 1990-2001, the risk factor for 48% of the cases was IDU, and 40.9% were attributed to heterosexual contact with a person living with HIV/AIDS (27.4%), an IDU (11%), a recipient of blood products (1.4%), or a bisexual male (1.1%).</p> <p>What has been learned from the few studies conducted and from experiences in the field is that many women who are at risk for HIV do not regularly use condoms, particularly with their main partners. (2, 3) Limited social and economic resources, dependence on a main partner, and risk factors, including exchanging sex for money or drugs and binge drinking, were found to be negatively related to the perceived ability to actively engage in behaviors that reduce risk. (2)</p> <p>Partners seem to significantly influence whether black women engage in protective behaviors, specifically condom use. One study of African American women in Alabama found that 45.3% did not use condoms. (3) The study also found that female partners of non-condom users were:</p> <ul style="list-style-type: none"> <li>• four times more likely to believe that asking their partner to use a condom implied he was unfaithful,</li> <li>• three times as likely to have a partner who resisted using condoms,</li> <li>• three times more likely to be recipients of public assistance</li> <li>• twice as likely to be sexually nonassertive, and</li> <li>• three times as likely to have had only one sexual partner.</li> </ul> <p>The study also suggested that the nature of the relationship also appears</p>

Population	Black / African American Heterosexual Females
	<p>to affect whether women engage in protective sexual behavior. The researchers found that protected sexual contact tends to be discontinued once women find themselves in a progressive, monogamous relationship. This was also supported by another study, which found that women who were married or had been in long-term relationships were less likely to seek treatment or be tested for HIV because these women felt there was no reason to since they had been in a monogamous relationship. (4)</p> <p>A study conducted by Howard University Hospital, in which 30 Black women were interviewed, including 28 that were HIV positive, suggests that Black women in Washington DC may have limited control over their decision to engage in safer sexual practices, and HIV prevention interventions targeting this group should address their experiences with violence, power imbalances and conflict resolution. (10)</p> <p>The risk factors for the women in the study were intravenous drug use and heterosexual contact. Six women (19%) in the Howard study reported that they had no control over whether or not a condom was used; thirteen (43%) reported that they had some control, and eleven (38%) reported that they had total control. There did not appear to be any direct effects on the safer sex practices of women based on financial dependence, condom use self-efficacy and self-esteem.</p> <p>In its series of community consultations, the HPCPG conducted a focused group discussion with seven African American women who are direct providers of HIV prevention and other services to this population. These service providers provided their opinion on whom among Black women in the District are most at risk: (5)</p> <ul style="list-style-type: none"> <li>• Women in Wards 7 and 8 (married or with a male partner) living in subsidized housing in Wards 7 and 8, between the ages of 20 and 39;</li> <li>• Female injecting drug users (IDU) or female partners of IDUs in Wards 6, 7 and 8;</li> <li>• Women whose partners have been recently released from prison/jail;</li> <li>• Middle class women whose male sex partners may be engaging in sex with other men on the “down low;” and</li> <li>• Female students on college campuses.</li> </ul> <p><b><u>Riskiness of Behavior:</u></b> The population engages in receptive vaginal intercourse and oral sex. Some young women also engage in receptive anal sex, some of them to preserve their virginity and some of them to avoid pregnancy.</p> <p>The CDC has estimated that the risk of receptive vaginal sex is 20 times higher than receiving oral sex (ROS), the risk of receptive anal sex is 100 times higher than ROS, and the risk of performing oral sex is two times higher than ROS.</p> <p><b><u>Prevalence of Risk Behaviors</u></b> The prevalence of risk behavior in the</p>

Population	Black / African American Heterosexual Females
<b>Challenges and Obstacles to Prevention (Difficulty Meeting need)</b>	<p>District is unknown. The San Francisco Prevention Planning Group has estimated that heterosexual women engage in unprotected receptive vaginal intercourse 77 a year, unprotected receptive anal intercourse 6 times a year, and giving fellatio, unprotected, 48 times a year.</p> <p><b><u>Multiple Risk Factors – A summary of the risk factors identified in the Risk Assessment section:</u></b></p> <p>Unprotected sex  High rate of AIDS among black heterosexual men  Men on the down low  Large number of Black men who have served time in prison or are incarcerated and will be released  Poverty among Black women as a factor in engaging in survival sex  Injecting drug use</p> <p>HIV interventions appear effective at improving knowledge about HIV and AIDS and increasing sexual risk reduction behaviors among women for all ethnic groups, with one exception. Interventions have been found to be less consistently effective for African-American women. (9)</p> <p>A study of Black women indicates that many women perceive themselves as victims in society and that this perception limits their propensity to take action to protect them from HIV. Successful HIV infection prevention interventions need to address negative social and economic factors that define the context of many women's lives. (6)</p> <p>No studies on the risk behavior of Black women in the District were identified during this needs assessment.</p>
<b>Recurring and Emerging Issues</b>	<p>Sexual assault has been identified as a key factor in high-risk behaviors. The dissemination of sexual assault prevention programs has become increasingly popular in recent years. (5, 7) HIV prevention efforts have recognized the relationship but have not addressed the prevention of sexual assault as a strategy for the prevention of HIV. (7)</p>
<b>Resources and Gaps</b>	<p>The Resource Inventory identified 20 HIV prevention programs that target Black women. In 2002, they expect to reach 39,304 black women.</p> <p>Several studies have found that outreach, group-level interventions, and community mobilization are effective interventions for Black heterosexual women. A 1996 study of an HIV prevention program for Black women in Virginia found that AIDS information and street outreach for this population is most effective when introduced by another Black woman. (10) The study also found that church support, participation from key community leaders and women living with HIV/AIDS are critical in educating this hard to reach population.</p> <p>The District programs that include Black women as a focus for prevention efforts provide the following array of interventions.</p>

Population	Black / African American Heterosexual Females
<b>Need for Additional Studies</b>	<ul style="list-style-type: none"> <li>• 14 provide Individual level interventions</li> <li>• 14 provide group level interventions</li> <li>• 10 provide prevention case management</li> <li>• 15 conduct outreach</li> <li>• 11 conduct Health Communications/Public Information programs</li> </ul> <p>There is a need for studies that identify the prevalence of risk behaviors among Black women. This includes studies that would examine the differences by age and country of origin (i.e., U.S., Caribbean and African-born women). More insight is also needed into the barriers to and motivating factors for risk reduction and on the effectiveness of health promotion strategies.</p>
<b>Sources of Data</b>	<ol style="list-style-type: none"> <li>1. District of Columbia Epidemiologic Profile 2001, District of Columbia Department of Health, HIV/AIDS Administration.</li> <li>2. Women's Health 2001;34(3):71-91 Factors related to self-efficacy for use of condoms and birth control among women at risk for HIV infection. Lauby JL, Semaan S, O'Connell A, Person B, Vogel A.</li> <li>3. American Journal of Community Psychology 1998 Feb;26(1):29-51 Partner influences and gender-related factors associated with non-condom use among young adult African American women. Wingood GM, DiClemente RJ.</li> <li>4. Bowleg, Lisa, &amp; Belgrave, Faye Z. "Gender Roles, Power Strategies, Precautionary Sexual Self-Efficacy: Implications for Black and Latina Women's HIV/AIDS Protective Behaviors." <i>Sex Roles: A Journal of Research</i>. April 2000</li> <li>5. HPCPG Community Consultation with providers of services for Black women, April 2002.</li> <li>6. Health Care Women Int 1999 Nov-Dec; 20(6):579-91 Perceived HIV-related sexual risks and prevention practices of African American women in the southeastern United States. Timmons SM, Sowell RL. College of Nursing, University of South Carolina, Columbia, USA</li> <li>7. Clinical Psychology Review 1999 Nov;19(7):739-71 Sexual assault prevention programs: current issues, future directions, and the potential efficacy of interventions with women. Yeater EA, O'Donohue W. University of Nevada, Reno, USA.</li> <li>8. St Lawrence JS, Eldridge GD, Brasfield TL. Behavioral and psychosocial consequences of HIV antibody counseling and testing with African American women. Women's Health 1998 Summer; 4(2): 135-53.</li> <li>9. Women's Health 1998 Summer;4(2):135-53 Behavioral and psychosocial consequences of HIV antibody counseling and testing with African American women. St Lawrence JS, Eldridge GD, Brasfield TL. Community Health Program, Jackson State University, USA.</li> <li>10. Hylton KK; Delapenha R; Frederick W; Howard University Hospital,</li> </ol>

<b>Population</b>	<b>Black / African American Heterosexual Females</b>
	Washington DC, USA. <i>Int Conf AIDS</i> . 1998;12:216 (abstract no. 14167).

<b>Population</b>	<b>Black / African American Heterosexual Males</b>
<b>Size of Population</b>	<p>81,600 (ages 18 –65 years)</p> <p>Extrapolated from the 2000 Census</p>
<b>AIDS Incidence: 1996-2001</b>	<p>New Cases of AIDS: 386 cases</p> <p>AIDS Rate: 47 Per 10,000 Population</p>
<b>General Characteristics of the Population</b>	<p>The Black population in the District of Columbia consists primarily of those who were born in the United States. However, a number of immigrants from various African countries and the Caribbean have chosen the District for their home. The Black population comprises 60% of the District's population.</p>
<b>Risk Assessment</b>	<p>For cases reported in the period 1990-2001, the risk factor for 48% of the AIDS cases among Black males was sex with another male (47.07%), IDU (31.66%), MSM/IDU (5.76%), and heterosexual contact (9.86%). For surveillance purposes, the CDC classifies heterosexual contact for men as sex with a person that has a history of injecting drug use, with a person living with HIV/AIDS, or with a person who has received a blood transfusion or blood products.</p> <p>Several studies indicate that some Black men continue to hold a number of misperceptions and myths about HIV and its transmission. (1) One study conducted in Houston found that a number of men believed that they could identify risky female partners by outward appearance and by odor. These men also believed that risk was greater depending on social class and they trusted their partners to provide accurate pictures of their sexual histories. In a study of African American male college students, patterns of serial monogamy were found to be associated with perceptions of reduced risk. (2)</p> <p>The studies on condom use among Black heterosexual men primarily examine men who were injecting drug users and adolescent males. Studies of heterosexual IDUs have found that primary sexual partners provide a sense of stability and introducing condoms might be viewed as disturbing the stability of the relationship. (3, 4)</p> <p>In a study of condom use among young Black heterosexual men, the men reported being more likely to use a condom to prevent pregnancy than to prevent disease. (5) Pregnancy prevention was a greater motivating factor. This study concluded that if pregnancy prevention is not a major concern, condom might be hampered.</p> <p><b><i>In the District of Columbia</i></b></p> <p>In a study conducted among Black men in the District in 2000-2001, 17% of respondents (621 individuals), reported they did not use condoms. Within this group, one out of four (26.6%) reported having</p>

Population	Black / African American Heterosexual Males
	<p>had sex with both men and women in the last 30 days. A third (33.5%) had been treated for a sexually transmitted disease (STD) at least once in the last 12 months. (6)</p> <p>The "Sexual Health Survey of Black Males in Washington, D.C.," conducted by Regional Addiction Prevention (RAP) and Health Evaluation Research Services (HERS), explored sexual attitudes, beliefs and behaviors of Black men ages 18 - 44. Over 3,600 men participated in the survey, which excluded those individuals who only had sex with other men. (6)</p> <p>Among all participants in the survey, 14% (518 individuals) reported that they regularly had sex with both men and women. Within this group, more than a third had had sex with three or more partners in the last 30 days. Three out of 10 said they did not expect to use a condom at their next sexual encounter.</p> <p>More than two-thirds (67%) of all respondents reported being tested at least once for HIV and 15.4% reported they had tested positive for the HIV virus at their last test.</p> <p>Among the 544 individuals who said they were HIV-positive, 70.6% expected to have sex in the next 30 days, and 21.1% said they did not expect to use condoms. More than a third of the men in this group (38.7%) said they would only use a condom if asked by their partner.</p> <p>Of the sample, 12.1% had been treated for STDs more than once during their lifetimes, and 10.9% had been diagnosed with Hepatitis C, which may be an indication of injecting drug use</p> <p>More than half of all respondents (52%) said they would use a condom if asked by their partner. Among the reasons given for not using condoms were:</p> <ul style="list-style-type: none"> <li>• concern over possible loss of erection</li> <li>• involved in monogamous sexual relationship</li> <li>• condoms interfered with sensitivity or felt unnatural</li> <li>• partner did not like the feel of condom</li> <li>• belief that partner is disease free</li> </ul> <p>Nearly one out of three men said that if they suggested using a condom they would be afraid of a partner's negative perceptions (e.g., that the partner suggesting a condom was infected with a disease or had engaged in homosexual behaviors).</p> <p>While a significant number of respondents noted that they imbibed alcohol or smoked marijuana before sex (42.9% and 34.8%, respectively), 65% of all respondents reported that they did not forget to wear condoms while high.</p> <p>Of the 1,880 men who reported only having sex with women in the last 30 days – 51% of the total number of survey participants) – nearly half</p>



Population	Black / African American Heterosexual Males
Challenges and Obstacles to Prevention (Difficulty Meeting need)	<p>reported always wearing a condom for vaginal sex. Excluding those men who reported that they did not engage in anal sex, 19% of those who did indicated that they never used a condom during anal sex.</p> <p><b><u>Riskiness of Behavior:</u></b> The CDC has estimated that the risk of insertive vaginal sex is 10 times riskier than receiving oral sex (ROS) and that insertive anal sex is 13 times riskier than ROS.</p> <p><b><u>Prevalence of Risk Behaviors</u></b> The prevalence of risk behaviors in the District is not known. The San Francisco Prevention Planning Group has estimated that heterosexual men engage in unprotected insertive vaginal intercourse 82 times a year, unprotected insertive anal intercourse 6 times a year. They receive fellatio, unprotected, 42 times a year and they give cunilingus, unprotected, 41 times a year.</p> <p><b><u>Multiple Risk Factors – A summary of the risk factors identified in the Risk Assessment section:</u></b></p> <ul style="list-style-type: none"> <li>• Unprotected vaginal and anal sex with multiple partners, both male and female</li> <li>• Unprotected sex with commercial sex workers</li> <li>• Injection and non-injecting drug use</li> </ul> <p>Most respondents to the RAP survey reported being informed about the transmission of HIV and this was supported by responses to knowledge based questions. Yet, the men still reported engaging in behaviors that put them and their sexual partners at risk for infection. While focus group participants had varied perspectives about their susceptibility to risk for contracting the virus, the one common theme throughout the discussion seemed to be consistent with the current knowledge that education and knowledge is only a partial solution for HIV prevention among Black males. (6)</p>
Recurring and Emerging Issues	<p>Black males continue to engage in high-risk behaviors that place them and their partners at risk for contracting HIV. Multiple risks include the concurrence of injection and or non- injecting drug use along with multiple partners.</p>
Resources and Gaps	<p>The Resource Inventory found nine HIV prevention programs that target this population. They expect to reach 11,417 black heterosexual men in 2002, which is 11% of the estimated population of 106,605.</p> <p>Studies have found that group-level interventions, individual-level interventions and social marketing have been effective in reducing risk behavior by Black heterosexual men. The programs that target Black heterosexual men in the District provide individual counseling, group level interventions, prevention case management and outreach interventions to this population.</p>

Population	Black / African American Heterosexual Males
Sources of Data	<ol style="list-style-type: none"> <li>1. Essien EJ, Meshack AF, Ross MW. (2002) Misperceptions about HIV transmission among heterosexual African-American and Latino men and women. <i>J Natl Med Assoc</i> 94 (5) 304-12</li> <li>2. Bazargan M, Kelly EM, Stein JA, Husaini BA, Bazargan SH. (2000) Correlates of HIV risk-taking behaviors among African-American college students: the effect of HIV knowledge, motivation, and behavioral skills. <i>Journal of the Nation Medical Association</i> 92 (8): 391-404</li> <li>3. Williams M, Ross MW, Bowen AM, Timpson S, McCoy HV, Perkins K, Saunders L, Young P. (2001). An investigation of condom use by frequency of sex. <i>Sexually Transmitted Infections</i>;77(6):433-5</li> <li>4. Sherman SG, Latkin CA. (2001) Intimate relationship characteristics associated with condom use among drug users and their sex partners: a multilevel analysis. <i>Drug and Alcohol Dependency</i>, 64(1):97-104.</li> <li>5. Cooper ML, Agocha VB, Powers AM. (1999) Motivations for condom use: do pregnancy prevention goals undermine disease prevention among heterosexual young adults? <i>Health Psychology</i> 18(5): 464- 74</li> <li>6. Survey of Heterosexual Behavior Among Black Men in Washington, D.C. (2001) Conducted by Regional Addiction Prevention, Inc and Health Evaluation Research Services. Funded by D.C. Department of Health, HIV/AIDS Administration.</li> </ol>

<b>Population</b>	<b>Blind and Physically or Developmentally Disabled</b>
<b>Size of Population</b>	<p>40,047</p> <p>1990 US Census</p> <p>During 1998, the age-adjusted prevalence of disability for the District of Columbia was estimated at 13.6% of the adult population, excluding institutionalized persons. (1)</p>
<b>AIDS Incidence: 1996-2001</b>	<b>Unknown</b>
<b>General Characteristics of the Population</b>	<p>The needs of the population are diverse, depending upon the specific disability and the level of disability. Some persons may have physical disabilities which only limit their mobility while others physical disabilities and related developmental affects.</p> <p>Developmental disabilities are often identified during early childhood years and often include mental retardation; language and learning disorders; cerebral palsy; autism, and sensory impairments (i.e., vision and hearing loss). As with most dysfunctions, the degree of severity can span a large range of complications and competencies. The services and care required for this population can vary from physical, emotional / psychological, speech / language or occupational therapies, as well as, educational.</p>
<b>Risk Assessment</b>	<p>There is little national data on HIV or AIDS cases or behavioral studies of persons with physical disabilities, the blind or partially sighted, or of persons with developmental disabilities. There are no such data on residents of the District of Columbia.</p> <p>The limited research does not address the at-risk behaviors that exist in institutions that house mentally retarded and developmentally disabled persons. In Germany, research on HIV prevention among the mentally impaired found that at least 50 % of adults with mental impairments (developmentally disabled) had experienced sexual contact and that the range of sexual behaviors mirrored the general population. (2) The research also found that sexual assaults on this population may go unreported because the victims do not recognize the act as an assault. The study concluded that HIV prevention strategies for this population had not been developed because of misperceptions about the sexuality of the developmentally disabled.</p>
<b>Challenges and Obstacles to Prevention (Difficulty Meeting need)</b>	<p><b>Physically disabled.</b> Visual messages do not typically have pictures of person who are physically disabled. Thus person with certain physical disabilities may not respond to prevention messages.</p> <p><b>Visually impaired.</b> While CDC has developed HIV prevention materials in Braille, little is known about the use of HIV prevention strategies for the visually impaired.</p>

<b>Population</b>	<b>Blind and Physically or Developmentally Disabled</b>
<b>Resources and Gaps</b>	The Resource Inventory identified one HIV prevention program that targets this population. It expects to reach 125 persons who are blind or have a physical disability during 2002.
<b>Need for Additional Studies</b>	There is a need for studies on the risk behaviors of the physically disabled, the blind and the developmentally disabled, and on the most appropriate interventions for these populations.
<b>Sources of Data</b>	<ol style="list-style-type: none"> <li>1. Center of Disease Control, MMWR August 11, 2000, 49 (31) 711-4). State Specific Prevalence of Disability Among Adults – 11 States and the District of Columbia, 1998.</li> <li>2. Whitman M; Matthey C; Dieck E; Messing K; Arbeitsgruppe AIDS beim Landesinstitut für Tropenmedizin Berlin,; FRG Prevention of HIV infection in the mentally impaired, featuring West-Berlin., Int Conf AIDS. 1989 Jun 4-9;5:746</li> </ol>

<b>Population</b>	<b>Commercial Sex Workers</b>
<b>Size of Population</b>	<p><b>Unknown</b></p> <p>The clandestine nature of the sex work makes it difficult to accurately estimate either the numbers or types of commercial sex workers (CSW) in the District. One local outreach worker estimated that on any given evening there are more than 500 CSWs working at the street level. (1)</p>
<b>AIDS Incidence: 1996-2001</b>	<p><b>Unknown</b></p>
<b>General Characteristics of the Population</b>	<p>Commercial sex workers (CSWs) include males, females, and transgendered individuals who engage in various forms of sex for gain. (2) The population is diverse, including youth, students, homeless, immigrants and others who cross the full spectrum of special populations and subgroups, racial, ethnic and class lines. The most visible CSWs are those who market their services on the street. Other venues, however, include massage parlors, temporary film sets, brothels, as well as individuals who work as escorts and advertise their services in different publications. CSWs include individuals who work in the sex industry full-time as well as those who work part-time or periodically. The population also includes transient and seasonal workers who are primarily based outside the District. Another factor contributing to the difficulty in painting an accurate portrait of these workers is the fact that many only work in the industry periodically, when they are between jobs or relationships. (4)</p>
<b>Risk Assessment</b>	<p>The combination of sexual risk behavior and injecting drug use results in high rates of HIV and AIDS among CSWs. (3) Unprotected sex and substance abuse, particularly injecting drug use, are key risk factors associated with the transmission of HIV among CSWs. In addition, drug-addicted CSWs are more apt to engage in risk behavior while high or be forced to engage in such behavior in exchange for drugs.</p> <p>While it may seem that some persons choose this profession, there are many others, including runaway or "throwaway" youth and homeless women, among others, who are forced, by another person or by circumstance, to engage in commercial sex work in order to secure food and shelter.</p> <p><b><i>In the District of Columbia</i></b></p> <p>Research on the sex practices of male street sex workers in the District found that while a majority reported worrying about AIDS, only a minority reported feeling personally at risk regarding AIDS. (5) This gap between general worrying and feeling personally vulnerable was reflected in the subjects' reported very high-risk sexual behaviors. (6) Other survey findings on sexual practices of male sex workers noted that male sex workers reported using condoms during anal sex, while few reported using them during oral sex. (7)</p>

Population	Commercial Sex Workers
	<p>Another aspect of risk behaviors exhibited by CSWs involves the extent to which CSWs interact with or are themselves members of other high-risk populations, such as ex-offenders. (8) This issue appears to be an emerging issue in HIV prevention in the District. A further emerging issue related to risk behaviors concerns the involvement of college women in the sex industry and the belief of many that their risk level is low because their customers are primarily middle- and upper middle-income males. (9)</p> <p>The people who are most vulnerable to HIV infection are street workers, many of who are poor or homeless, and many of who are young, have a history of childhood abuse and are likely to be drug or alcohol dependent. Street prostitutes are extremely vulnerable to violence from clients, police, and sometimes their lovers. Male and female sex workers who work off the street (in brothels, massage parlors, their own apartments, or escort services) are much less likely to become infected, largely because they are less likely to depend on drugs or alcohol and more likely to be able to control the sexual transaction and insist on condoms. (16)</p> <p>A study of 1,396 female sex workers in six US cities found an HIV seroprevalence of 12%, ranging from 0 to 47.5% depending on the city and the level of injecting drug use. (17) A study of 235 male street sex workers in Atlanta, GA, found 29.4% seroprevalence, with highest rates among those who had receptive anal sex with nonpaying partners. (17)</p> <p>Injecting drug use was the main risk factor for HIV infection for female sex workers in six US cities. (16) Female injecting drug users who trade sex for money or drugs are more likely to share needles than female injectors who do not engage in sex trading, and are less likely to use new needles or to clean old ones. (18)</p> <p><b><u>Riskiness of Behavior.</u></b> The CDC has estimated that the risk of unprotected receptive vaginal sex is 20 times higher than receiving oral sex (ROS) and the risk of receptive anal sex is 100 times higher than ROS. Insertive anal sex is 13 times higher than receiving oral sex (ROS) and unprotected insertive vaginal sex is 10 times riskier than ROS. Performing oral sex is two times riskier than ROS.</p> <p><b><u>Prevalence of Risk.</u></b> There are no studies on the prevalence of risk behavior among commercial sex workers in the District, but exposure to multiple sexual partners can be assumed to occur among all commercial sex workers.</p> <p><b><u>Multiple Risk Factors – A summary of the risk factors identified in the Risk Assessment section:</u></b></p> <p>Five factors contribute to high HIV risks among CSWs: 1) injecting drug use and needle-sharing; 2) level of control over terms and conditions of sexual encounter; 3) denial of risk and belief in a low level of personal vulnerability; 4) inaccurate and incomplete knowledge about</p>

Population	Commercial Sex Workers
<b>Challenges and Obstacles to Prevention (Difficulty Meeting need)</b>	<p>HIV, its transmission, and risk behaviors; and 5) non-job risk exposure (e.g. unprotected sexual encounters with a partner or bartering unprotected sex for necessities).</p> <p>In an examination of the impact of violence, interpersonal power, financial dependence, condom use, and self-esteem on safer sex practices among African American women in the District, it was found that numerous obstacles limited the women's control over their decision to engage in safer sexual practices. (10) In some urban areas it is common practice for police officers to confiscate condoms from street prostitutes – thus increasing their risk. CSWs interviewed as part of a study by the Center for AIDS Prevention Studies at the University of San Francisco cited the following additional risk factors: faulty condoms that break, allowing oils to come in contact with the condom, and not maintaining control of the condom or the sexual encounter. (11)</p> <p>The clandestine and illegal nature of the sex industry makes it difficult for the public health system to target CSWs, particularly non-street workers, and implement effective prevention strategies. Fear of being "outed" and reported to law enforcement by health care providers, as well as fears that such an action may lead to incarceration as well as loss of children, keep many CSWs from coming forward to seek health assistance. (1)</p> <p>In the Washington DC area, there are an increasing number of immigrants, some of who may ultimately resort to sex work for economic survival. HIV prevention initiatives directed toward this population may be hampered by language and cultural barriers, compounded by fear created from engaging in illegal activities. More information is needed on the specific risk behaviors of this group. (5)</p>
<b>Recurring and Emerging Issues</b>	<p>As with their male counterparts, incarcerated females have higher rates of HIV and IV drug use than the non-incarcerated community. (13) Both the returning felon and street CSW often share the same neighborhoods and social networks, and it is likely that these two populations will come together to engage in paid as well as unpaid sexual activity.</p>
<b>Resources and Gaps</b>	<p>The Resource Inventory identified three HIV prevention programs that target this population. They expect to reach 1,782 individuals from the target population during 2002.</p> <p>Among the three programs, two provide individual counseling, two provide group level interventions, all three provide outreach, and two operate HC/PI initiatives. There were no PCM programs for this population.</p> <p>Campaigns targeting CSWs have been highly successful in other countries. A nationwide campaign to promote 100% condom use during commercial sex resulted in continued and long term decreases in HIV seroprevalence among male and female sex workers in Bangkok. (14) More than 100 experts at the 2001 UN General Assembly's session on</p>

Population	Commercial Sex Workers
<b>Need for Additional Studies</b>	<p>HIV/AIDS presented evidence supporting the effectiveness of this and other harm reduction strategies for preventing AIDS. (15) Drop-in clinics, street level outreach, condom distributions, needle exchanges, and peer health education have also been identified as effective prevention strategies -- in particular, where these strategies have the support and cooperation of law enforcement (thus, reducing the threat of arrest for clients).</p> <p>To prevent HIV infection among commercial sex workers, it is essential to address the context in which sex work is transacted, as well as the specific practices of the sex workers. There is a need for studies on the risk behaviors of sex workers, including youth, transgendered persons and immigrants, and on the most appropriate interventions for this population.</p>
<b>Sources of Data</b>	<ol style="list-style-type: none"> <li>1. Telephone interview with C.M.C., an outreach worker and CSW advocate in the District, July 29, 2002.</li> <li>2. This definition of CSW is one used by the DC-based HIPS (Helping Individual Prostitutes Survive), the Commercial Sex Information Service (CSIS), UNAIDS Care and Prevention, among others.</li> <li>3. Lyons, Catherine RN, MS, MPH, ANP and Rita Fahrner RN, MS, PNP, "HIV in women in the sex industry and/or injecting drug users," Clinical Issues in Prenatal and Women's Health Nursing, AIDS in Women, Vol. 1 Number 1. 1989.</li> <li>4. Ward H, Day, S; Weber, J "Risky Business: Health and Safety in the Sex Industry over a 9-Year Period." <i>Sexually Transmitted Infections</i>, October 1999. 75(5): 340-3.</li> <li>5. Snell, CL "Male sex workers in Washington, DC: Sexual Practices and Outreach Services" , paper presented at International Conference on AIDS, June 16-21, 1991.</li> <li>6. Snell CL; Jones AB "Psycho-social aspects of male prostitution in Washington, DC" paper presented at International Conference on AIDS, June 4-9, 1989.</li> <li>7. Ziersch A; Gaffney J; Tomlinson DR STI prevention and the male sex industry in London: Evaluating a Pilot peer Education Programme" <i>Sexually Transmitted Infections</i> Vol. 76 No. 6, 447-53. December 2000</li> <li>8. Dievler, A. et al "Implications of social class and race for urban public health policy making: A case study of HIV/AIDS and TB policy in Washington, DC",. US GAO, Washington, DC HEHS 1095-102 (1999)</li> <li>9. Telephone interview with C.M.C., an outreach worker and CSW advocate in the District, July 29, 2002.</li> <li>10. Hylton KK, Delapenha R, Frederick W "Psychosocial determinants of HIV preventive behavior among black women in Washington, DC", presented at International Conference on AIDS, 1998</li> <li>11. What are Substance Abusers' HIV Prevention Needs? Center for AIDS Prevention Studies, University of California at San Francisco, 1998.</li> <li>12. Kassira EN, etal," HIV and AIDS Surveillance among Inmates in Maryland</li> </ol>



Population	Commercial Sex Workers
	<p>Prisons," Journal of Urban Health Policy Vol. 78 No. 2, 256-63 June 2001</p> <p>13. Kilmarx PH; Palanuvej T; etal "Seroprevalence of HIV Among Female Sex Workers in Bangkok: Evidence of Ongoing Infection Risk After the '100% Condom Program' was Implemented," Journal of Acquired Immune Deficiency Syndrome. 1:21(4):313-6 August 1999</p> <p>14. The Open Society Institute (pubs.), "Drugs, AIDS and Harm Reduction: How to Slow the HIV Epidemic in Eastern Europe and the Former Soviet Union" report of expert panel at the UN General Assembly special session on HIV/AIDS, June 26, 2001.</p> <p>15. Alexander, P. "Occupational Safety and Health Regulations as an HIV/AIDS Prevention Strategy in the Context of Sex Work," XI International Conference on AIDS abstract (1996) disseminated by Commercial Sex Information Service.</p> <p>16. Centers for Disease Control and Prevention. Antibody to human immunodeficiency virus in female prostitutes. Morbidity and Mortality Weekly Report. 1987;36:157-161.</p> <p>17. Elifson KW, Boles J, Sweat M. Risk factors associated with HIV infection among male prostitutes. American Journal of Public Health. 1993;83:79-83.</p> <p>18. Kail BL, Watson DD, Ray S. Needle using practices within the sex industry. American Journal of Drug and Alcohol Abuse. 1995;21;241-255.</p>

<b>Population</b>	<b>Deaf and Hard of Hearing</b>
<b>Size of Population</b>	<p>24,026</p> <p>According to the US Census Bureau (1997), 3.8% of Americans over the age of 15 have difficulty hearing and 0.4% are unable to hear. (1) Applying national estimates, there would be 24,026 deaf and hard of hearing (D&amp;HH) persons living in the District. However, the proportion of this population residing in the District is assumed to be greater than national estimates because of the presence of Gallaudet University. Many deaf persons are drawn to this metropolitan area for the educational opportunities and often choose to maintain permanent residence, enjoying access to an established deaf community and a well developed social support system for the deaf.</p>
<b>AIDS Incidence: 1996-2001</b>	<p><b>Unknown</b></p> <p>The District does not collect data on D&amp;HH individuals who test HIV positive or on the number of AIDS cases among the deaf and hard of hearing. Maryland, which has a sizable deaf community living in the Washington-Baltimore corridor, was the first state to include questions about deafness in its HIV counseling and testing forms. Maryland estimates that 4.3% of its deaf population is HIV positive. (4)</p>
<b>General Characteristics of the Population</b>	<p>The deaf and hard of hearing population includes persons who have some form of hearing loss, from the profoundly deaf, who hear no sounds, to the hard of hearing, who hear sounds but cannot consistently discern and distinguish sounds. The experience of deafness varies and there are a number of terms used to explain the heterogeneity among deaf persons. Late onset deaf and late deafened adult are terms used to distinguish those person who loss their hearing as adults. The deaf are also distinguished by whether the onset of deafness occurred before or after the development of language skills. Pre-lingually deaf are those who lost their hearing before age three. Post-lingually deaf lost their hearing after age three. (2)</p> <p>According to the US Health Interview surveys, 8.6% of the total US population three years of age and older reported having hearing problems. This hearing loss runs along a continuum from mild to profound. Those with mild loss will not hear everything in a noisy setting and those with moderate losses require hearing devices. For persons with severe to profound hearing loss, hearing aids may be of limited or no help. Persons with this degree of hearing loss rely on written notes, speech reading (lip-reading), gestures, computers, sign language, finger spelling, text telephones (TTs) interpreters, and ingenuity. (3)</p>
<b>Risk Assessment</b>	<p>The deaf are particularly vulnerable to HIV infection because of language barriers, their unique culture, and the paucity of community services, educational programs, and general information directed to this population.</p>

Population	Deaf and Hard of Hearing
<b>Challenges and Obstacles to Prevention (Difficulty Meeting need)</b>	<ul style="list-style-type: none"> <li>• HIV and sexuality education in schools for the deaf appear to be limited, especially for adolescents. Consequently, are less knowledgeable about HIV transmission and prevention. (5)</li> <li>• There is a high prevalence of substance use and abuse among deaf persons, with one in seven deaf persons having substance abuse problems compared with estimates of 1 in 10 hearing persons. (6)</li> </ul> <p><i><b>In the District of Columbia</b></i></p> <p>A 1995 survey of students at Gallaudet University in the District of Columbia – which provides services to the deaf – found that 50% of the 84 respondents did not use condoms during heterosexual sex, and that 95% did not use condoms during oral sex. Most of the respondents (86%) obtained their information about HIV/AIDS from newspapers, books and magazines. (7)</p> <p>Deaf students in the District were found to have significantly lower scores on an “HIV/AIDS Knowledge Index” than hearing students, a difference that could not be explained by gender, class standing or family structure. Deaf students obtained more of their information from family and friends. While hearing students relied more on teachers, television and reading materials. (7)</p> <p>Efforts have been made to reach the deaf community through targeted HIV/AIDS education, but some findings indicate that D&amp;HH individuals, many of whom are isolated from hearing communities due to linguistic and cultural distinctions, may not be completely receiving the messages.</p> <p>A 1989 study by the Ontario Association of the Deaf (8) found that:</p> <ol style="list-style-type: none"> <li>1. Profoundly deaf persons whose primary language is American Sign Language generally have limited English skills, usually below grade 4 level. Thus, current AIDS materials are inaccessible to them.</li> <li>2. AIDS information is passed socially from one deaf person to another rather than through mass media. Misconceptions are spread quickly and are extremely difficult to challenge without direct access to deaf social networks.</li> </ol> <p>Communication barriers when seeking health care in general further exacerbate this. (7) A study on health care utilization found that deaf individuals reported a number of problems communicating their health needs to providers. The implications are that deaf persons are less likely to seek care and advice from their health care provider and less likely to share information about their HIV risk behaviors. (2)</p>
<b>Recurring and Emerging Issues</b>	<p>The District of Columbia has a proportionately sizable deaf population in large part due to the presence of Gallaudet University. The unique HIV prevention and intervention needs of this segment of the population are</p>

<b>Population</b>	<b>Deaf and Hard of Hearing</b>
	significant, and effective education and outreach methods are necessary.
<b>Resources and Gaps</b>	The Resource Inventory identified one organization that provides HIV prevention interventions for this population. It expects to reach 6,434 individuals, including both heterosexual men and women and gay/bisexual men.
<b>Need for Additional Studies</b>	There is a need for behavioral studies on the risk behaviors of the deaf and hard of hearing, and on the most appropriate interventions for these populations.
<b>Sources of Data</b>	<ol style="list-style-type: none"> <li>1. US Census Bureau (2001) Americans With Disabilities, Household Economic Studies, 1997 Population Reports</li> <li>2. Barnett, S and Franks, P. (1994) Healthcare Utilization by Prelingually and Postlingually Deafened Adults: A new Look at the 1990 - 1991 National Health Interview Survey Data. Rochester, NY: University of Rochester, Primary Care Institute</li> <li>3. Center for Disease Control and Prevention, US Health Interview Survey, 1995.</li> <li>4. Department of Health and Mental Hygiene, State of Maryland, 1999</li> <li>5. Baker-Duncan N, Dancer J, Gentry B, et al. Deaf adolescents' knowledge of AIDS. Grade and gender effects. <i>American Annals of the Deaf</i>. 1997;142:368-372.</li> <li>6. Peinkoffer JR. HIV education for the deaf, a vulnerable minority. <i>Public Health Reports</i>. 1994;109:390-396.</li> <li>7. Heutel, K.L. and Rothstein, W.G. (2001) HIV/AIDS Knowledge and information sources among deaf and hearing college students. <i>American Annals of the Deaf</i>, 146 (3):280-6</li> <li>8. Upton, K; Kerr, G; Perreault, Y. Deaf outreach project on AIDS. <i>Int Conf AIDS</i>. 1989 Jun 4-9;5:700 (abstract no. T.D.O.16). Ontario Association of the Deaf, Toronto, Ontario, Canada.</li> </ol>

295	395
-----	-----

Population	Homeless
<b>Size of Population</b>	<p>7,468 (5,750 adults and 1,718 children)</p> <p>Source: Homeless Enumeration for the Washington Metropolitan Region 2002, prepared by the Homeless Services Planning and Coordinating Committee of the Washington Metropolitan Council of Governments. May 2002. The estimate is based on a one-day point-in-time survey conducted on January 24, 2002. Survey data are based on the HUD definition of homelessness: "Sleeping in places not meant for human habitation, and sleeping in shelters or transitional or supportive housing for homeless persons who originally came from the streets or emergency shelters."</p>
<b>AIDS Incidence: 1996-2001</b>	<p>New AIDS cases: 295</p> <p>Rate: 395 per 10,000 population</p> <p>A study funded by the National Institutes of Drug Abuse found that, in 16 US cities, 3.4% of the homeless population was HIV-positive, versus 1% of the general population. (1)</p> <p>In Philadelphia, individuals admitted to public shelters had a three-year rate of subsequent AIDS diagnosis of 1.8 per 100 person, which is nine times the rate for the general population of Philadelphia. (2)</p>
<b>General Characteristics of the Population</b>	<p>According to the report of the Metropolitan Washington Council of Governments, the homeless population consists of the following groups of persons in rank order of magnitude for the Washington region.</p> <ul style="list-style-type: none"> <li>• Persons who chronically abuse drugs (23%)</li> <li>• Person who are seriously mentally ill (14%)</li> <li>• Domestic violence victims (10%)</li> <li>• Dually diagnosed (9%)</li> <li>• Military veterans (6%)</li> <li>• Physically disabled (6%)</li> <li>• People living with HIV/AIDS (3%)</li> </ul> <p>Twenty seven percent of the adult homeless in the District are employed, and 57% of homeless adult and children are males.</p> <p>The report did not provide estimates of the homeless by race or ethnicity.</p>

Population	Homeless
Risk Assessment	<p>Among the homeless are individuals with multiple risk factors such as persons who are homeless as a result of substance abuse or mental illness. Homelessness is also a motivating factor for engaging in what is frequently referred to as survival sex – sex in exchange for money or a place to live.</p> <p>The principal factors that put this population at-risk are unprotected sex with multiple partners; injecting drug use; sex with IDU partners; and exchanging unprotected sex for money, shelter, food, or drugs. Almost half (45%) of those surveyed in a NIDA study indicated that they practice at least two of the at-risk behaviors combined. Other respondents (26%) indicated three or more practices of at-risk behaviors combined. (2)</p> <p>In a study involving women who are homeless, data indicates that 8% of the women injected drugs, 64 % of the women engaged in unprotected sex and 22% traded sex for various bartering circumstances. (3)</p> <p>One study, of homeless youth in Atlanta, found that knowledge and attitudes about condoms among homeless youth was comparable to those of other adolescents described in the literature. (4) In fact there appeared to be a strong knowledge of HIV/AIDS, yet the sexual behavior and attitudes toward condom use were not consistent with this knowledge. This mirrors findings from other studies on homeless youth. (5)</p> <p><b><i>In The District Of Columbia</i></b></p> <p>The HPCPG convened a community consultation with three service providers, to discuss the HIV prevention needs of the homeless, injecting drug users and the mentally ill, as there appears to be significant overlap among these groups. (6) The providers reported the following risk behavior:</p> <ul style="list-style-type: none"> <li>• Unprotected anal, vaginal, oral sex</li> <li>• Sex under the influence of drugs and alcohol</li> <li>• Sex in exchange for drugs and alcohol</li> <li>• Needle sharing</li> <li>• Non consensual sex -- rape, forced sex was reported as frequent among female's who misuse drugs and are homeless</li> </ul> <p><b><u>Riskiness of Behavior:</u></b></p> <p>Studies indicate that the some of the population engages in injecting drug use, which has a high relative risk for HIV, when unsterilized, needles or works are used. Given the lack of living quarters, homeless persons who are IDU may be less likely to be able to have access to and keep clean works.</p> <p>The CDC has estimated that the risk of receptive vaginal sex is 20 times higher than receiving oral sex (ROS), the risk of receptive anal sex is 100 times higher than ROS, and the risk of performing oral sex is two</p>

Population	Homeless
<b>Challenges and Obstacles to Prevention (Difficulty Meeting need)</b>	<p>times higher than ROS. Insertive vaginal sex is 10 times riskier than ROS, and insertive anal sex is 13 times riskier than ROS.</p> <p><b><u>Prevalence of Risk Behaviors</u></b> In one study it was found that almost half (45%) of those surveyed at least two of the at-risk behaviors combined and a little more than one out of four (26%) engaged in three or more at-risk behaviors combined. (2)</p> <p><b><u>Multiple Risk Factors – A summary of the risk factors identified in the Risk Assessment section:</u></b></p> <ul style="list-style-type: none"> <li>• Drug use</li> <li>• Chronic mental illness</li> <li>• Victims of physical and sexual abuse</li> <li>• Unprotected sex in exchange for money, shelter or drugs</li> </ul> <p>Barriers to prevention are also evidenced with approaches that do not address the immediate concern of homelessness. (2) Risk reduction education might be better received if the primary concerns of the homeless were first met. (4) This includes addressing the need for shelter, mental health services, drug treatment services and other social supports. The community consultation reported that homeless individuals have difficulty storing condoms in order to be prepared for sexual encounters. (6)</p> <p>Unique barriers also exist for sub populations among the homeless.</p> <p>Transgendered homeless experience difficulty-seeking shelter because placement of individuals is based on gender (same-sex accommodations). This is further compounded by the biases of shelter personnel and of other shelter residents. (6)</p> <p>Among homeless substance-abusing immigrants another obstacle is the fear of seeking services for fear of the INS, and the practical difficulties associated with frequently losing important documents on the street. During the community consultation, providers reported that the Park Police have sometimes torn-up the immigration document of their homeless clients when arresting them. (6)</p>
<b>Recurring and Emerging Issues</b>	<p>It appears that the HIV rate is significantly higher among the homeless as compared to the general population. Study findings suggest that nearly half of homeless persons engage in multiple high-risk behaviors. (1, 2)</p>
<b>Resources and Gaps</b>	<p>The Resource Inventory identified six HIV prevention programs that target this population. They expect to reach 4,690 individuals in 2002.</p>
<b>Need for Additional Studies</b>	<p>There is a need for behavioral studies on the risk behaviors of the homeless population in the District, and on the most appropriate interventions for this population.</p>

Population	Homeless
Sources of Data	<ol style="list-style-type: none"> <li>1. American Journal of Drug and Alcohol Abuse. (1998). Prevalence of HIV infection and HIV risk behaviors associated with living place: on-the-street homeless drug users as a special target population for public health intervention (The NIDA Cooperative Agreement for AIDS Community-Based Outreach / Intervention Research Program) (National Institute on Drug Abuse). Author: Geoffrey A.D. Smereck.</li> <li>2. Culhane DP, Gollub E, Kuhn R, Shpaner M (2001) The co-occurrence of AIDS and homelessness: results from the integration of administrative databases for AIDS surveillance and public shelter utilization in Philadelphia. <i>J Epidemiol Community Health</i> 2001 Jul;55(7):515-20</li> <li>3. Kilbourne AM, Herndon B, Andersen RM, Wenzel SL, Gelberg L. (2002). Psychiatric symptoms, health services and HIV risk factors among homeless women. <i>Journal of Health Care for Poor and Underserved</i> 13 (1): 49-65.</li> <li>4. Liverpool J, McGhee M, Lollis C, Beckford M, Levine D. (2002). Knowledge, attitudes, and behavior of homeless African American adolescents: implications for HIV/AIDS prevention. <i>Journal of the National Medical Association</i> 94(4):257-63.</li> <li>5. Tyler K. (2000). Predictors of Self-reported Sexually Transmitted Diseases Among Homeless and Runaway Adolescents. <i>The Journal of Sex Research</i>.</li> <li>6. DC HIV Prevention Community Planning Group, Needs Assessment Committee, Community Consultation with providers of services to IDUs, Substance Abusers, the Homeless and the Mentally Ill, May 2002</li> </ol>



<b>Population</b>	<b>Immigrants</b>
<b>Size of Population</b>	<p>73,561</p> <p>Source: 2002 Washington Metropolitan Council of Governments</p>
<b>AIDS Incidence: 1996-2001</b>	<b>Unknown</b>
<b>Risk Assessment</b>	<p>Many new immigrants to the District have arrived here fleeing civil unrest and bring histories of trauma and abuse; it is estimated that as many as 80% may be plagued by post traumatic stress disorder. Characteristically, these factors precipitate low self-esteem, self-destructive tendencies and high-risk behaviors. (1) A risk trend is drug use, including injecting drug use. For new immigrants, this combined with daily survival in their new homeland relegates HIV/AIDS to just another problem to contend with.</p> <p>Impoverished living circumstances among immigrants increase the likelihood of other risk behavior. Evictions are a common occurrence. Families who cannot afford housing pool resources and large numbers live in overcrowded small apartments where children are exposed to sexual activity between adults. Alcohol use is also prevalent. (1)</p>
<b>Challenges and Obstacles to Prevention (Difficulty Meeting need)</b>	<p>According to representatives of clinics serving primarily Latino immigrants in the District, many people have stopped seeking services since the September 11, 2001 attacks. There appears to be a fear of visiting agencies due to heightened anxiety from media reports and increased enforcement of deportation orders. In addition, clients now appear to be less likely to use condoms and to adhere to medical treatment. (1) Overall, existing barriers among particularly recent immigrants include low education, lack of knowledge of HIV prevention, low income, machismo and poverty. (2)</p> <p>Key informant interviews with persons in leadership positions of social support organizations serving African immigrants identified fear of risking deportation if tested for HIV or if other health services are sought. Reportedly, a number of African immigrants came to the United States on school visas. They may have completed school and decided to stay and not longer have valid visas.</p>
<b>Recurring and Emerging Issues</b>	<p>According to community representatives, over the next three years immigration will continue to increase, but employment will be difficult and more people will engage in sex work. It is also anticipated that recently arrived immigrants will have less access to services. (1)</p> <p>New immigrants may know little about HIV prevention issues. Clinics and hospitals will need to improve their cultural and linguistic competency. Currently, accessible culturally and linguistically appropriate care is inadequate, especially in hospitals. (1)</p>
<b>Resources and Gaps</b>	There are programs that address the needs of the Latino and Asian and

<b>Population</b>	<b>Immigrants</b>
	Pacific Islander populations, some of who are recent immigrants, but there were no programs identified that specifically focused on the prevention needs of recent immigrant.
<b>Need for Additional Studies</b>	There is a need for behavioral studies on the risk behaviors of recent immigrants, including Blacks from the Caribbean and Africans, Central Americans, and Asians and Pacific Islander, particularly those who do not speak English, and on the most appropriate interventions for these populations.
<b>Sources of Data</b>	<ol style="list-style-type: none"> <li>1. District of Columbia HIV Prevention Community Planning Group, Community Consultation on Immigrants. April 2002.</li> <li>2. Gutierrez J; Moses PA; Crespo C; Torres G; Mora S; Lopez D; Mendez A. Techniques to train recent Latin American immigrants with low literacy as peer-educators in the Washington, DC area. Int Conf AIDS. 1998; 12:1098.</li> </ol>

<b>Population</b>	<b>Incarcerated, Re-Entry, Ex -offenders</b>
<b>Size of Population</b>	<p>10,150 men and women</p> <p>Over 2,500 former prisoners return home to the District each year. Currently about 7,000 people are under active supervised release in the District. This figure includes probationers and parolees, individuals sentenced in the Superior Court for the District of Columbia, as well as individuals under pretrial supervision pending disposition of their cases in court. (1)</p>
<b>AIDS Incidence: 1996-2001</b>	<p>New AIDS Cases: 256</p> <p>AIDS Rate: 252 Per 10,000 Population</p>
<b>General Characteristics of the Population</b>	<p>The overwhelming majority District's prison population, 97%, is African American males. African American and other minority females make up about 10% of the re-entry population. On any given day, nearly half of young African American men in the District are in prison or jail, or on probation, parole or pretrial release. Most of the District's female prisoners are unmarried and have children. (1)</p>
<b>Risk Assessment</b>	<p>Compared with non-incarcerated person, prisoners re-entering the community have higher rates of serious infectious diseases, including HIV and AIDS; substance abuse, including injecting drug use and addiction; chronic diseases (e.g., diabetes, asthma, coronary, etc.); and mental health issues. (2)</p> <p>Two-thirds (both males and females) have a history of substance abuse, including a high prevalence of injecting drug use. A significant number are HIV positive or habitually engage in high- risk behaviors.</p> <p>Sexual activity between male inmates is not uncommon in prisons and jails. A Federal Bureau of Prisons study in 1982 reported that 30% of federal prison inmates engaged in homosexual activity while incarcerated. (17)</p> <p>The risk behaviors of returning prisoners mirrors those of other populations, with perhaps two exceptions: (a) prisoners are more likely to be injecting drug users and share needles; and, (b) prisoners are more likely to have engaged in unprotected sexual contact (consensual and non-consensual) while incarcerated. The large proportion of female offenders who are HIV-positive and are mothers to children under seven years of age presents another aspect to the prevention response. (3) A small number of female offenders give birth while incarcerated and there is an increased risk of babies who are born HIV-positive.</p>
<b>Recurring and Emerging Issues</b>	<p>The District of Columbia's long-term correctional facility closed in the fall of 2001. Prisoners that had been housed at the facility were sent to</p>

Population	Incarcerated, Re-Entry, Ex -offenders
<b>Challenges and Obstacles to Prevention (Difficulty Meeting need)</b>	<p>federal prisons in other parts of the country. Prisoners in these facilities cannot be reached through District of Columbia programs and services, even though many of these prisoners will be returning to the District when they are released.</p> <p>Although efforts are being made to provide transitional services upon release, there is still evidence of unstable transition for the recently released. Most felons re-enter the community either directly or through halfway house or transitional living situation. According to CSOSA, the number of returnees needing such services is greater than the number of transitional beds that currently exist. (4, 5)</p> <p>Better more organized release process is needed to ensure that all returnees, within the first month of actual release and return to DC, go through healthcare enrollment and assessment and subsequent health/prevention education. (6)</p> <p>A critical barrier to adequately addressing the HIV prevention needs of re-entry prisoners is the potential "double jeopardy" situation created by the corrections system. For example, released felons who are HIV-positive or who are at great risk of HIV as a result of injecting drug use may be reluctant to seek healthcare services or be forthcoming about the problem because the admission of drug-use is a clear violation of most conditions of release. Thus, the person must choose between the honesty required to get appropriate care and the potential and likely threat that he or she will be re-incarcerated for violating the terms and conditions of release. (2)</p>
<b>Resources and Gaps</b>	<p>The Resource Inventory identified one program that targets ex-offenders returning to the District. It expects to reach 500 individuals in 2002.</p>
<b>Need for Additional Studies</b>	<p>There is a need for behavioral studies on the risk behaviors of these groups, and on the most appropriate interventions for these populations.</p>
<b>Sources of Data</b>	<ol style="list-style-type: none"> <li>1. AJ Beck, "Prisoners in 1999" <i>Bureau of Justice Statistics, Bulletin</i>, Washington, DC: US Dept. of Justice, Bureau of Justice Statistics, NCJ 1183476, August 2000</li> <li>2. TM Hammett "Health-Related Issues in Prisoner Reentry to the Community" unpublished paper for the Reentry Roundtable, Urban Institute, Washington, DC October 12-13, 2000</li> <li>3. BE Richie "Issues Incarcerated Women Face When They Return to Their Communities" unpublished paper for the Reentry Roundtable, Urban Institute, Washington, DC October 12-13, 2000</li> <li>4. "Prisoner Releases: Information on Reintegration Programs" Report to Congressional Committees, US GAO, GAO-01-483, 2001.</li> <li>5. J Travis, "Prisoner Releases in the District of Columbia" Testimony before US House Committee on Government Reform Subcommittee on the District of Columbia, July 20, 2001</li> <li>6. J. Travis, "But They All Come Back: Rethinking Prisoner Reentry"</li> </ol>

Population	Incarcerated, Re-Entry, Ex -offenders
	<p><i>Sentencing &amp; Corrections, Issues for the 21<sup>st</sup> Century</i>, 7: Washington, DC: National Institute of Justice, NCJ 181413, 2000.</p> <p>7. Nacci P, Kane T. Sex and sexual aggression in federal prisons. Washington: Federal Bureau of Prisons, 1982</p>

<b>Population</b>	<b>Injecting Drug Users (IDU)</b>
<b>Size of Population</b>	<p>9,720 (including 5,832 Blacks/African Americans, 2,994 whites and 768 Latinos)</p> <p>Source: Estimates from a study by the DC Department of Health, Addiction Prevention and Recovery Administration (APRA)</p>
<b>AIDS Incidence: 1996-2001</b>	<p>New AIDS Cases: 1,447 (including 1,386 cases among Blacks/African Americans)</p> <p>AIDS Rate: 44 per 10,000 population (for Blacks/African Americans it is 78 per 10,000 population)</p>
<b>General Characteristics of the Population</b>	<p>This population is defined by a specific behavior – injecting drug use, which can transmit HIV if individuals share needles and other materials used for injecting drugs, including cookers, that are tainted with the blood of an HIV-positive individual. The population cuts across groups defined by gender, race and sexual orientation. The drugs of choice include heroin, cocaine and methamphetamine. The proportion of reported AIDS cases transmitted among heterosexual IDUs is greatest in ward 7 and 8 of the District of Columbia, suggesting that these two ward also have a higher proportion of IDU residents. (1)</p> <p>IDUs also transmit the virus through sexual behaviors.</p>
<b>Risk Assessment</b>	<p>Injecting drug use is the second most common mode of transmission of HIV among men in the District, after sex between men, and the most common form of HIV transmission for women. (1)</p> <p>The 2000 Household Survey on Substance Abuse conducted by the Addiction, Prevention and Recovery Administration found that about 1,700 (less than 0.4%) of the District non-institutionalized population 12 years and older reported using heroin during the 30 days prior to the survey. (10)</p> <p>HIV risk behaviors have been found to vary greatly depending on the social network of the IDU. In a study of the social networks of injecting drug users in Chicago and Washington, D.C., individual behavior and network characteristics (strength of relationship/affiliation, size and movement in and out of networks over time) were examined. (11) The study found that movement into a drug network was a significant predictor of increased risky injecting drug use (i.e., sharing unclean works). The study concluded that such movement was indicative of a “lack of a stable resource base among the IDU networks.”</p> <p>A 1993 study of HIV-positive men who used illicit drugs in Atlanta, Washington, D.C., and San Juan, Puerto Rico, found that they continued to have unprotected sex. The study, which was conducted by the Centers for Disease Control and Prevention, was based on interviews with 116 men who were injecting drug users and were known to be HIV-positive. Twenty-eight percent of the men reported having sex without a condom,</p>

Population	Injecting Drug Users (IDU)
	<p>and were significantly more likely than those who used condoms to report other high risk sexual behaviors, such as multiple sex partners and trading sex for money or drugs. An editorial accompanying the study says the results emphasize the need for HIV-infected individuals to have ongoing counseling about safe sex practices. (15)</p> <p>Nationally, the spread of HIV infection among injecting drug users who share needles and works is the second most common mode of HIV transmission, next to sexual contact. Unprotected sexual contact is a significant risk factor to the spread of HIV by the IDU population. (2)</p> <p>While many drug users have the same network of sexual partners who are also involved in substance use, there are others whose partners are not part of the drug use network. In either case, unprotected sexual activity with regular or casual partners increases the risk for spreading HIV. (3) “Rapid partner change,” which refers to having multiple sexual partners over time, was cited in a surveillance study of the IDU population as a phenomenon that increased opportunities for HIV transmission by sexual contact. (2). Research has shown that illicit drug users who have received substance abuse treatment were less likely to share needles because their treatment addressed utilization of clean needle; however, IDUs continued to participate in risky sexual behaviors by not utilizing condoms (4).</p> <p>Studies have also found that IDUs are less likely to use condoms with their regular partner. Unprotected sexual encounters also may lead to pregnancy placing both the IDU partner at risk but also the unborn child. Children born to IDU mothers are at risk if there has not been any prenatal care. (5, 6, 7)</p> <p>The injection drug of choice has also been found to increase both injection drug risk factors as well as risky sexual behavior. In a Denver study of MSM who also inject drugs, cocaine was the primary injecting drug of choice (90%). Additionally, 59% injected methamphetamine. Both drugs were chosen to stimulate sexual desire. (8) The study found that that cocaine injection increased the likelihood for sharing unsterilized works. Further, condom use for this population was found to be inconsistent for all types of sex (anal and oral, as well as vaginal among MSM who also had sex with women).</p> <p>The IDU population has also been known to use sex as a means to support their drug addiction. Being under the influence of drugs a person is more apt to take risk such as having unprotected sex. (3)</p> <p>There is research that suggests that the underlying factors contributing to an illicit drug user’s risky behavior stem from personality, relationships, and ecological and cultural factors (4). In other words, a person with low self-esteem, dysfunctional relationships and an unstable household is more apt to participate in risky behaviors such as illicit drug use and unsafe sexual practices. (4)</p> <p>Among injecting drug users, those who had more people present during drug use were more likely to share needles, while those with more</p>

Population	Injecting Drug Users (IDU)
	<p>emotional support were less likely to share needles, suggesting that personal relationships strongly influence continued injecting drug use. (9)</p> <p>Many IDUs have never been tested for HIV and are not aware of their HIV status. These individuals continue to engage in drug use risk behavior as well as unprotected sexual encounters. Service providers have an idea who these individuals may be but need to devise a plan to service these individuals.</p> <p>In Baltimore, promoting needle disinfection by IDUs was found to be associated with reduced drug risk behavior but did not improve needle hygiene practices over time. (12). The most effective strategy for IDUs who are not in treatment is needle exchange (5, 13). Such harm reduction approaches do not seek to eliminate drug use, instead focusing on minimizing the personal and social harms and costs associated with drug use and the spread of HIV. While needle exchange effectively reduces the risk for HIV among injecting drug users, there are those within the substance abuse treatment community who are concerned that the exchange of needles allows the continued use of drugs. This dilemma is also played out in the politics of the District, which is subject to Congressional oversight. The requirement that the District obtain approval from Congress to spend local dollars has resulted in riders being added to the District budget, which preclude the District from funding needle exchange programs with its own or federal funds.</p> <p>Contrary to the belief that needle exchange might increase drug use, studies have found that drug use has decreased when treatment and counseling are provided simultaneously. (5, 14).</p> <p>The CDC funded the development of a guide on HIV Prevention Among Injecting drug users that calls for a comprehensive approach to working with IDUs to eliminate the spread of HIV in that population. The guide, developed for the CDC by the Academy for Educational Development, recommends a comprehensive approach to reduce the transmission of HIV among IDUs. (1)</p> <p>This approach includes several strategies:</p> <p><b>Substance Abuse Treatment</b>, because most drug users cannot stop using without it, and it helps users reduce drug- and sex-related behaviors.</p> <p><b>Community Outreach</b>, to reach IDUs who don't participate in conventional service systems and help create a culture of risk reduction in the community, which helps reinforce prevention messages.</p> <p><b>Access to Sterile Syringes</b>, to help ensure that IDUs who continue to inject drugs will not acquire or transmit HIV.</p> <p><b>Services in the Criminal Justice System</b>, because high-risk sex and drug-use behavior occurs in jails and prisons and prevention interventions benefit inmates and the communities to which almost all will return.</p>



Population	Injecting Drug Users (IDU)
	<p><b>Strategies to Prevent Sexual Transmission</b>, because IDUs are an important source of sexual transmission of HIV and hepatitis B and high-risk drug use and sex behaviors are often linked.</p> <p><b>Counseling and Testing Services, Partner Counseling and Referral Services, and Prevention Case Management</b>, because they allow IDUs to find out whether they are infected with HIV, they allow infected IDUs access to counseling and medical care and other services, and they help infected IDUs inform sex and drug-use partners.</p> <p><b>Services for IDUs Living with HIV/AIDS</b>, because they can help infected IDUs reduce high-risk drug and sex behaviors and because infected IDUs who receive substance abuse treatment and other health services are more likely to comply with medication regimens</p> <p><b>Primary Drug Prevention</b>, because preventing first use of alcohol, marijuana, inhalants, and other drugs among youth can reduce the risk that they will go on to use injection drugs and preventing injecting drug use eliminates injection-related blood-borne virus transmission</p> <p><b><u>Riskiness of Behavior:</u></b> The San Francisco Prevention Planning Group has estimated that sharing unsterile needles for injecting drug use is 12 times as risky as performing oral sex on a male. By comparison, unprotected receptive vaginal intercourse is 3 times as risky and unprotected anal intercourse is 9 times as risky.</p> <p><b><u>Prevalence of Risk Behaviors:</u></b> There are no studies on the prevalence of risk behavior among IDUs in the District. The San Francisco Prevention Planning Group has estimated that IDUs share unclean needles 39 times a year.</p> <p><b><u>Multiple Risk Factors – A summary of the risk factors identified in the Risk Assessment section:</u></b></p> <ul style="list-style-type: none"> <li>• Sharing unsterile needles</li> <li>• Unprotected sex (all types)</li> <li>• Other drug use</li> <li>• Multiple sex partners</li> </ul> <p>The concern about injecting drug use has generally focused on the use of heroin, and more recently the injection of cocaine. However, focus groups in the District of Columbia with transgendered individuals uncovered the practice of needle sharing for the injection of hormones, especially among transgendered youth.</p>
<b>Recurring and Emerging Issues</b>	
<b>Resources and Gaps</b>	There are a number of substance abuse treatment programs. There is

Population	Injecting Drug Users (IDU)
	<p>only one needle exchange program operating in the District of Columbia supported by private funds.</p> <p>The Resource Inventory identified three HIV prevention programs that target IDUs, including one needle exchange program. These programs expect to reach 5,634 IDUs in 2002.</p> <p>Several studies have found that group-level interventions and outreach, including needle exchange programs, are effective in reducing the HIV risk behavior of IDUs. The three organizations that target this population provide individual counseling, group level intervention, prevention case management and outreach, including needle exchange.</p> <p>An HIV outreach intervention entitled Project Neighborhoods in Action that conducted an intervention with injecting drug users and crack users in several inner-city neighborhoods in the District of Columbia with more than 1,600 persons resulted in significant decreases in risk behaviors (i.e., decreases in drug usage, needle sharing, trading sex for money or drugs, and having sex while high). (16)</p>
<b>Need for Additional Studies</b>	<p>More data is needed on the drug use patterns of IDUs in the District of Columbia, the prevalence of sharing of drug injection equipment, the availability of injection equipment, sexual risk behaviors and participation in and effectiveness of prevention activities.</p>
<b>Sources of Data</b>	<ol style="list-style-type: none"> <li>1. DC. Department of Health, HIV/AIDS Administration, AIDS in Washington DC 1995 – 2000, Selected Risk Indicators by Ward</li> <li>2. Des Jarlais DC, Dehne K, Casabona (2001) HIV surveillance among injecting drug users. J. AIDS Apr;15 Suppl 3:S13-22</li> <li>3. Edin, R P Brettle MD. (N.d.). Injecting drug use (IDU). Retrieved February 2002, from <a href="http://www.link.med.ed.ac.uk/RIDU//Hxidu.htm">http://www.link.med.ed.ac.uk/RIDU//Hxidu.htm</a></li> <li>4. Williams, Mark L. (1998). A Cluster Analysis of not-in-treatment drug users at risk for HIV infection. (The NIDA Cooperative Agreement for AIDS Community-Based Outreach/Intervention Research Program)(National Institute on Drug Abuse). <i>American Journal of Drug and Alcohol Abuse</i></li> <li>5. American Academy of Pediatrics, Provisional Committee on Pediatric AIDS. Reducing the Risk of Human Immunodeficiency Virus Infection Associated With Illicit Drug Use. <i>Pediatrics</i>. 1988; 101:933-935</li> <li>6. Office of Communications and Public Liaison, National Institute of Allergy and Infectious Diseases, and National Institute of Health. (1999). Education &amp; Support Center HIV and Adolescents. <i>The Journal of the American Medical Association</i>.</li> <li>7. Brook, David W. (2000). Needle Sharing: A Longitudinal Study of Female Injecting drug users. <i>American Journal of Drug and Alcohol Abuse</i>.</li> <li>8. Bull, SS., Piper, P., and Rietmeijer, C. (2002) Men who have sex with men and also inject drugs-profiles of risk related to the synergy of sex and drug injection behaviors. <i>Journal on Homosexuality</i>,42(3): 31-51</li> <li>9. Gogineni A, Stein MD, Friedmann PD.(2001) Social relationships and intravenous drug use among methadone maintenance patients. <i>Drug Alcohol Depend</i> 1;64(1):47-53</li> </ol>

Population	Injecting Drug Users (IDU)
	<ol style="list-style-type: none"> <li>10. DC Department of Health Addiction Prevention Recovery Administration (2001) 2000 Household Survey on Substance Abuse</li> <li>11. Hoffmann JP, Su SS, Pach A.(1997) Changes in network characteristics and HIV risk behavior among injecting drug users. <i>Drug Alcohol Depend</i> 6;46(1-2):41-51</li> <li>12. Celentano DD, Cohn S, Davis RO, Vlahov D J <i>Urban Health</i> 2002 Jun; 79(2): 245-56 Self-efficacy estimates for drug use practices predict risk reduction among injecting drug users.</li> <li>13. U. S. Department of Health and Human Services. (1998). Needle Exchange Programs: Part of A Comprehensive HIV Prevention Strategy (HHS Press Office 202 690-6343). Washington, DC.</li> <li>14. Zarkin, Gary A. (2001). The Cost and Cost-Effectiveness of an Enhanced Intervention for People with Substance Abuse Problems at Risk for HIV. <i>Health Services Research</i>.</li> <li>15. Kalichman, S.C. Continued Sexual Risk Behavior Among HIV-Seropositive, Drug- Using Men--Atlanta; Washington, D.C.; and San Juan, Puerto Rico, 1993, <i>Morbidity and Mortality Weekly Report (02/23/96) Vol. 45, No. 7, P. 151</i></li> <li>16. Hoffman JA, Klein H, and Crosby H, Clark DCUS Project neighborhoods in action: an HIV-related intervention project targeting drug abusers in Washington, DC. <i>J Urban Health</i> 1999 Dec; 76(4):419-34</li> </ol>

<b>Population</b>	<b>Latino Heterosexuals</b>
<b>Size of Population</b>	<p>29,475</p> <p>Extrapolated from the 2000 Census</p>
<b>AIDS Incidence: 1996-2001</b>	<p>New AIDS Cases: 45</p> <p>AIDS Rate: 15 per 10,000 population</p>
<b>Overview</b>	<p>An increasing number of HIV infections are impacting the Latino population within the United States. The 2000 United States Census Report records that Latinos represent 13% of the country's population (including residents of Puerto Rico). According to the Centers for Disease Control and Prevention (CDC), the AIDS incidence rate per 100,000 population (the number of new cases of a disease that occur during a specific time period) among Latinos was 22.5 in 2000, more than 3 times the rate for whites (6.6), but lower than the rate for African Americans (58.1).</p> <p>The majority of AIDS cases among the Latino population in the United States in 2000 were concentrated among those born in the continental U.S. (35%) and Puerto Rico (25%), followed by those born in Mexico (13%), Central or South America (8%) and Cuba (2%). An additional 18% were reported from Latinos with unknown place of birth (15%) or born elsewhere (3%). (2)</p> <p>The District of Columbia has a diverse Latino population. Many Latinos come here from a vast array of historical and cultural backgrounds.</p> <p>The 11,741 Salvadorans living in the District in 2000 make up the largest group of Latinos in the District, which had 44,953 Latino residents in 2000, according to the U.S. Census. Central Americans make up 35% of the District's Latino population.</p> <p>After Salvadorans, the next largest groups of Latinos by country of origin were Mexicans (5,098 or 11%); Puerto Ricans (2,328 or 5%); Dominicans (1,496 or 3%); Guatemalans (1,350 or 3%); Cubans (1,101 or 2%); Colombians (859 or 2%); and Hondurans (853 or 2%).</p> <p>HIV risk dynamics among immigrant and migrant Latinos can be more complex than among US born Latinos, as they are dealing with conflicting cultural norms while trying to adjust to life in a new country. For some, this results in higher risk; for others, lower risk. Levels of acculturation, poverty, employment, migrant labor conditions and connection to traditional Latino values can influence HIV risk. (1)</p> <p>The analysis of risk for the population is presented in the next two sections by gender.</p>
<b>Sources of Data</b>	<ol style="list-style-type: none"> <li>Organista K, Carillo H, Ayala G. HIV prevention with Mexican migrants: review, critique and recommendations. In press.</li> <li>Centers for Disease Control and Prevention. HIV/AIDS Surveillance Report, Year End Edition. 2000;12.</li> </ol>

<b>Population</b>	<b>Latina Heterosexual Women</b>
<b>Size of Population</b>	<p>13,221</p> <p>Extrapolated from the 2000 Census</p>
<b>AIDS Incidence: 1996-2001</b>	<p>New AIDS Cases: 19</p> <p>AIDS Rate: 14 cases per 10,000 population</p>
<b>General Characteristics of the Population</b>	<p>Latinos primarily reside in three communities in the District: Mount Pleasant, Columbia Heights and Petworth. The District is home to thousands of Central American immigrants from El Salvador, Guatemala, Honduras and Nicaragua. As relatively new arrivals, Central Americans are a large and culturally unique Latino subgroup. Central American immigrants are distinguished from other Latino sub-populations through culture, dialect, mannerisms and colloquialisms.</p> <p>The 11,741 Salvadorans living in the District in 2000 make up the largest group of Latinos in the District, which had 44,953 Latino residents in 2000, according to the U.S. Census. Central Americans make up 35% of the District's Latino population.</p> <p>After Salvadorans, the next largest groups of Latinos by country of origin were Mexicans (5,098 or 11%); Puerto Ricans (2,328 or 5%); Dominicans (1,496 or 3%); Guatemalans (1,350 or 3%); Cubans (1,101 or 2%); Colombians (859 or 2%); and Hondurans (853 or 2%).</p>
<b>Risk Assessment</b>	<p>Salient HIV risk factors for Latina women are the culturally entrenched gender roles of female docility and male machismo. Male dominance and female submissiveness may translate into instances of sexual coercion and even sexual abuse. In a national study, one in five Latina women reported sexual abuse and rape in their lifetime. (1)</p> <p>Traditionally in Latino cultures, sex and sexuality are not discussed. For some Latina women, this sexual silence dictates that they should not know about or talk to men about sex because it suggests promiscuity. Therefore, their ability, comfort and success in insisting on condom use with male partners may be limited. (11).</p> <p>Unmarried Latina women are reluctant to suggest condom use to their sexual partners because they fear a perception of promiscuity. (2)</p> <p>In 2000, 65% of AIDS cases among Latina women were attributed to sex with men, and 32% to injecting drug use. In the same year, 47% of AIDS cases among Latino men were attributed to sex with men, 33% to injecting drug use, and 14% to sex with women. (10)</p> <p><b><i>In the District of Columbia</i></b></p> <p>Latina women acknowledge that machismo might inhibit condom use because women remain naïve to or silent about spousal infidelity. (3)</p>

## Population

### Latina Heterosexual Women

The commonality of multiple sexual partners among married Latino men, especially those with drug or alcohol abuse problems, poses increased risk to their partners. (4)

A new trend of older recent immigrant Latina women in relationships with younger Latino men who have more than one sex partner appears to increase their HIV risk. (4)

A study in the Petworth community found that young Latinos engage in anal sex to avoid pregnancy and believe there is low or no disease transmission via anal sex. (5)

There appears to be an increased incidence of alcoholism among Latina immigrants and many of these ostracized women have resorted to prostitution and high-risk sexual activity. (4)

**Riskiness of Behavior:** Among Latina heterosexual women, the most likely risk for disease transmission appears to be associated with male partners, who in some cases have more than one sex partner or who also have sex with men. According to the CDC, the risk of unprotected receptive vaginal sex is 20 times higher than receiving oral sex (ROS), the risk of receptive anal sex is 100 times higher than ROS, and the risk of performing oral sex is two times higher than ROS.

**Prevalence of Risk Behavior:** The prevalence of risk behavior in the District is unknown. The San Francisco Prevention Planning Group has estimated that heterosexual women engage in unprotected receptive vaginal intercourse 77 a year, unprotected receptive anal intercourse 6 times a year, and giving fellatio, unprotected, 48 times a year.

**Multiple Risk Factors:** Among some segments of Latina women, impoverishment and joblessness appears to correlate with the use of drugs, mainly alcohol, and initiation into commercial sex work.

## Challenges and Obstacles to Prevention (Difficulty Meeting need)

Cultural norms may impede the promotion of HIV prevention strategies. Gender roles of male dominance and machismo and female docility and submissiveness often serve to hamper the adoption of safer sex practices like condom use. In addition, frank discussions of sex are often avoided and considered inappropriate.

The Latino community is culturally diverse and therefore needs approaches that are culturally and linguistically appropriate and competent and address varying levels of acculturation. For example, less acculturated Latina women have been found to engage in more risky sexual behavior. (6)

Among recent immigrants, barriers include low education, lack of knowledge of HIV prevention, low income, machismo and poverty. (7)

## Recurring and Emerging Issues

The immigrant population, particularly from Central America, is increasing. Many immigrants bring histories of trauma and abuse that

## Population

### Latina Heterosexual Women

precipitate low self-esteem, self-destructive tendencies and high-risk behaviors. (3) Programs are needed that offer ancillary wrap-around services such as medical support, job training and employment, and immigration assistance alongside HIV prevention efforts. Also, Latino men and women should receive instruction aimed at enhancing their interpersonal communication skills and ability to negotiate matters related to emotional and sexual relationships and gender roles.

One effective prevention strategy implemented in the DC metro area employed peer educators to increase awareness of HIV transmission and prevention among Latinos. (7)

A culturally and linguistically appropriate competent HIV education outreach intervention conducted in the DC metro area significantly increased self-reported knowledge of HIV/AIDS as well as knowledge about disease transmission. (8)

A study designed to assess the impact of a multifaceted prevention program for Latina Immigrant women on HIV risk behaviors found that addressing a broad array of sociocultural issues enhanced skills needed to prevent disease transmission from their partners. (9)

## Resources and Gaps

The Resource Inventory identified four HIV prevention programs that target Latina women. One of the four expects to reach 3,340 Latino heterosexuals in general in 2002 and does not target specifically by gender. The other three programs anticipate reaching a combined total of 6,934 Latina heterosexuals (29.2 % of this population).

Several studies have found that group-level interventions are effective in reducing risk behavior among Latinos.

The four programs that include Latina women as a focus for prevention efforts provide the following types of interventions:

- 1 provides partner counseling and referral services
- 2 provide individual level interventions
- 3 provide group level interventions
- 1 provides prevention case management programs
- 4 conduct outreach
- 3 provide health communications/public information

## Unanswered Questions

There is a dearth of research specifically addressing prevention and intervention needs and HIV risk taking behavior of Latina women in the District. In addition, scant information exists on the HIV/AIDS knowledge, attitudes and related behaviors of recent Central American immigrants. Further, there may be differences that need to be addressed in attitudes, beliefs and behaviors dependent upon the country of origin. There is a need for studies on the most appropriate interventions for these populations

## Population

### Sources of Data

## Latina Heterosexual Women

1. Marin BV; Gomez CA; Grinstead OA. The gender gap: what young unmarried Latinos think and do about sex. Int Conf AIDS. 1994 Aug 7-12; 10 (1):15 (abstract no. 034 D). Ctr. For AIDS Prevention Studies, University of California, San Francisco.
2. Marín BV; Gómez C. Latinos, HIV Disease, and Culture: Strategies for HIV Prevention, January 1994.
3. Focus Group Report, DC Public Benefits Corporation, September 1998.
4. District of Columbia HIV Prevention Community Planning Group. Community Consultation: Immigrants. April 30, 2002.
5. District of Columbia Department of Health, HIV/AIDS Administration, Report on the Rapid Assessment of HIV Prevention and Care in Four Washington, D.C. Neighborhoods. October 2001.
6. Hines AM; Caetano R. Alcohol and AIDS related sexual behavior among Hispanics: acculturation and gender differences. AIDS Educ Prev 1998 Dec; 10(6): 533-47.
7. Gutierrez J; Moses PA; Crespo C; Torres G; Mora S; Lopez D; Mendez A. Techniques to train recent Latin American immigrants with low literacy as peer-educators in the Washington, DC area. Int Conf AIDS. 1998; 12:1098.
8. Crespo CJ; Gutierrez J; Moses P; Kirsten W; Loria C, Torres G; Mora S. Changes in the knowledge and attitudes about HIV and AIDS among recent Central and South American immigrants in the Washington, DC area. Int Conf AIDS. 1998; 12:926-7.
9. Gómez CA; Hernández M; Faigles B. Sex in the new world: an empowerment model for HIV prevention in Latina immigrant women. Health Educ Behav 1999 Apr; 26 (2) 200-12.
10. Centers for Disease Control and Prevention. HIV/AIDS Surveillance Report, Midyear Edition. 2001;13.
11. Gómez CA, Marín BV. Gender, culture and power: barriers to HIV prevention strategies for women. The Journal of Sex Research. 1996;33:355-362.



<b>Population</b>	<b>Latino Heterosexual Males</b>
<b>Size of Population</b>	<p>16,254</p> <p>Extrapolated from the 2000 Census</p>
<b>AIDS Incidence: 1996-2001</b>	<p>New AIDS Cases: 26</p> <p>AIDS Rate: 16 cases per 10,000 Population</p>
<b>General Characteristics of the Population</b>	<p>Latinos primarily reside in three communities in the District: Mount Pleasant, Columbia Heights and Petworth. The District is home to thousands of Central American immigrants from El Salvador, Guatemala, Honduras and Nicaragua. As relatively new arrivals, Central Americans are a large and culturally unique Latino subgroup. Central American immigrants are distinguished from other Latino sub-populations through culture, dialect, mannerisms and colloquialisms.</p>
<b>Risk Assessment</b>	<p>Male machismo and dominance are pervasive themes in the Latino community. Within the general Latino culture, sexual conquest is considered an exertion of masculinity. (1) Unmarried Latina women are reluctant to suggest condom use because they fear the perception of being sexually experienced or promiscuous. At the same time Latino men may assume their partner's silence suggests condom use is unnecessary. (2)</p> <p>In 2000, 47% of AIDS cases among Latino men in the United States were attributed to sex with men, 33% to injecting drug use, and 14% to sex with women. In the same year, 65% of AIDS cases among Latina women were attributed to sex with men, and 32% to injecting drug use. (7)</p> <p>The majority of AIDS cases among the Latino population in the United States in 2000 were concentrated among those born in the continental U.S. (35%) and Puerto Rico (25%), followed by those born in Mexico (13%), Central or South America (8%) and Cuba (2%). An additional 18% were reported from Latinos with unknown place of birth (15%) or born elsewhere (3%). (8)</p> <p><b><i>In the District of Columbia</i></b></p> <p>The use of alcoholic beverages before or during sexual relations seems to be a pervasive risk factor for HIV within the District's Latino community, especially among males. Crack use is also becoming another HIV aggravating risk factor. Men, including married men, particularly those with drug or alcohol problems, are likely to have multiple sex partners. Another risk marker is the growing number of sex workers on District streets, and much sex work is done without the use of a condom. (3)</p>

Population	Latino Heterosexual Males
Challenges and Obstacles to Prevention (Difficulty Meeting need)	<p>A recent study of the Petworth community uncovered Latino youth engaging in anal and oral sex in public laundromats. (4) Anal sex is often used to avoid pregnancy and it is sometimes falsely believed that anal sex decreases the chances of contracting a sexually transmitted disease. (3)</p> <p>Another risk trend is injecting drug use. For new immigrants, this, coupled with daily survival in the their new homeland, relegates HIV to just another problem to contend with. Some young Latinos arrive in the District from various Central American countries unescorted and unsupervised. For young men, the options are few and some engage in "survival sex" with older men. (4)</p> <p><b><u>Riskiness of Behavior:</u></b> The CDC has estimated that the risk of insertive vaginal sex is 10 times riskier than receiving oral sex (ROS) and that insertive anal sex is 13 times riskier than ROS. Receptive anal sex is 100 times higher than ROS, and the risk of performing oral sex is two times higher than ROS. The San Francisco Prevention Planning Group has estimated that sharing unsterile needles for injecting drug use is 12 times as risky as performing oral sex on a male. By comparison, unprotected receptive vaginal intercourse is 3 times as risky and unprotected anal intercourse is nine times as risky.</p> <p><b><u>Prevalence of Risk Behavior:</u></b> The prevalence of risk behavior in the District is unknown. The San Francisco Prevention Planning Group has estimated that heterosexual men engage in unprotected insertive vaginal intercourse 82 times a year and in unprotected insertive anal intercourse 6 times a year. They receive fellatio, unprotected, 42 times a year and they give cunilingus, unprotected, 41 times a year.</p> <p><b><u>Multiple Risk Factors:</u></b> Some findings suggest that unprotected sexual activity with multiple partners is common among heterosexual Latino males, especially those who also use drugs (including injection drugs) and alcohol.</p>
	<p>Cultural values that reinforce traditional beliefs about gender and the lack of safe sex practices are impediments to successful prevention efforts. Orthodox cultural norms preclude women and men from openly discussing sex. However, Latino men are generally given vast freedom when navigating the sexual landscape and are likely to have more than one sexual partner.</p> <p>Barriers among some Latinos, particularly recent immigrants, include low education, lack of knowledge of HIV prevention, low income, machismo and poverty. (5) Many bring histories of trauma and abuse that precipitate low self-esteem, self-destructive tendencies and high-risk behaviors. There are often multiple issues to contend with such as the combination of drug use, alcohol use and promiscuity. These deeply embedded and difficult to resolve characteristics become impediments to preventive practices.</p>

Population	Latino Heterosexual Males
<b>Recurring and Emerging Issues</b>	<p>The immigrant population, particularly from Central America, is increasing. Many immigrants bring histories of trauma and abuse that precipitate low self-esteem, self-destructive tendencies and high-risk behaviors. (4) Programs are needed that offer ancillary wrap around services such as medical support, job training and employment, and immigration assistance along side of HIV prevention efforts.</p> <p>Services should incorporate discussion and negotiating skills between Latino men and women regarding sexual practices and condom use. In addition, programmatic efforts should include education and resources related to the risk-heightening effects of alcohol and drug use.</p> <p>One effective prevention strategy implemented in the DC metro area employed peer educators to increase awareness of HIV transmission and prevention among Latinos. (5)</p> <p>A culturally and linguistically appropriate competent HIV education outreach intervention conducted in the DC metro area significantly increased self-reported knowledge of HIV as well as knowledge about disease transmission. (6)</p>
<b>Resources and Gaps</b>	<p>The Resource Inventory identified four HIV prevention programs that target Latino heterosexual men. One of the four intends to reach 3,340 Latino heterosexuals in general in 2002 and does not target specifically by gender. The other three programs anticipate reaching a combined total of 8,802 Latino heterosexual males.</p> <p>Several studies have found that individual-level and group-level interventions are effective in reducing risk behavior among Latinos.</p> <p>The four programs that include Latino heterosexual men as a focus for prevention efforts provide the following types of interventions for this population.</p> <ul style="list-style-type: none"> <li>• 1 provides partner counseling and referral services</li> <li>• 2 provide individual level interventions</li> <li>• 3 provide group level interventions</li> <li>• 1 provides prevention case management programs</li> <li>• 4 conduct outreach interventions</li> <li>• 3 provide health communications/public information</li> <li>•</li> </ul>
<b>Unanswered Questions</b>	<p>There is a need for behavioral studies on the risk behaviors of the deaf and hard of hearing, and on the most appropriate interventions for these populations. Further, there may be differences that need to be addressed in attitudes, beliefs and behaviors dependent upon the country of origin.</p>
<b>Sources of Data</b>	<ol style="list-style-type: none"> <li>1. District of Columbia Department of Health, HIV/AIDS Administration. HIV Prevention Plan, Population Specific Prevention Needs.</li> </ol>

Population	Latino Heterosexual Males
	<ol style="list-style-type: none"> <li>2. Marín BV; Gómez C. Latinos, HIV Disease, and Culture: Strategies for HIV Prevention, January 1994.</li> <li>3. District of Columbia HIV Prevention Community Planning Group, Community Consultation: Immigrants. April 2002.</li> <li>4. District of Columbia Department of Health, HIV/AIDS Administration, Report on the Rapid Assessment of HIV Prevention and Care in Four Washington, D.C. Neighborhoods. October 2001.</li> <li>5. Gutierrez J; Moses PA; Crespo C; Torres G; Mora S; López D; Mendez A. Techniques to train recent Latin American immigrants with low literacy as peer-educators in the Washington, DC area. International Conference on AIDS. 1998; 12:1098</li> <li>6. Crespo CJ; Gutierrez J; Moses P; Kirsten W; Loria C, Torres G; Mora S. Changes in the knowledge and attitudes about HIV and AIDS among recent Central and South American immigrants in the Washington, DC area. International Conference on AIDS. 1998; 12:926-7.</li> <li>7. Centers for Disease Control and Prevention. HIV/AIDS Surveillance Report, Midyear Edition. 2001;13.</li> <li>8. Centers for Disease Control and Prevention. HIV/AIDS Surveillance Report, Year End Edition. 2000;12.</li> </ol>

Population	Men who have Sex with Men (MSM)
<b>Size of Population</b>	<p>18, 941</p> <p>Source: based on a formula proposed by Scott D. Holmberg, MD, MPH in <i>The Estimated Prevalence and Incidence of HIV in 96 Large US Metropolitan Areas</i>, in combination with 2000 US Census Bureau data.</p>
<b>AIDS Incidence: 1996-2001</b>	<p>New AIDS cases: 1,676</p> <p>AIDS rate: 105 cases per 10,000 population</p>
<b>Overview</b>	<p>Between 1990 and 2001, 6,662 cases of AIDS were diagnosed among men who have sex with men (MSM) in the District. This represents 56% of all AIDS cases. (1)</p> <p>The proportion of cases in this category varies widely by race/ethnicity. In white men, 88% of cases were MSM. By contrast, 67% of cases among Latino men were MSM, while 47% of cases in Black/African American men were MSM.</p> <p>The proportion of MSM/IDU cases was 5.3% among all men. Black /African American males represented a slightly larger percentage, while the percentage among White and Hispanic/Latino men was slightly less.</p> <p>Nationally, even though the toll of the epidemic among injecting drug users (IDUs) and heterosexuals has increased during the last decade, MSM continue to account for the largest number of people reported with AIDS each year. In 2000 alone, 13,562 AIDS cases were reported among MSM, compared with 8,531 among IDUs and 6,530 among men and women who acquired HIV heterosexually. (2)</p> <p>Ongoing studies show that both the HIV prevalence ratio (the proportion of people living with HIV in a population) and the prevalence of risk behavior remain high among some young MSM. In a sample of 15-22 years old MSM in seven urban areas, CDC researchers found that, overall, 7% already were infected with HIV. Higher percentages of African Americans (14%) and Hispanics (7%) were infected than were whites (3%). (2)</p> <p>In the 34 areas with confidential HIV reporting, data show that substantial numbers of MSM still are being infected, especially young men. In 2000, 59% of reported HIV infections among adolescent males aged 13-19 and 53% of cases among men aged 20-24 were attributed to male-to-male sexual contact.</p>
<b>Sources of Data</b>	<ol style="list-style-type: none"> <li>1. HIV/AIDS Administration, Epidemiologic Profile of the District of Columbia, 2002.</li> <li>2. Centers for Disease Control and Prevention, Need for Sustained HIV Prevention Among Men who Have Sex with Men</li> </ol>

Population	Asian and Pacific Islander MSM
Size of Population	<p>398</p> <p>Source: based on a formula proposed by Scott D. Holmberg, MD, MPH in <i>The Estimated Prevalence and Incidence of HIV in 96 Large US Metropolitan Areas</i>, in combination with 2000 US Census Bureau data.</p>
AIDS Incidence: 1996-2001	<p>New AIDS Cases: 14</p> <p>Rate: 28 per 10,000 population</p>
Risk Assessment	<p>In the District of Columbia, 31 cases of AIDS had been reported among Asians and Pacific Islanders (API) as of December 31, 1998, of whom 27 were MSM.</p> <p>Many Asian and Pacific Islander (API) MSM do not perceive themselves to be at risk for HIV. For example, a study of gay API men in San Francisco, CA, found that 24% of the men reported unprotected anal intercourse, 85% believed they were unlikely to contract HIV, and 95% believed they were unlikely to transmit HIV. (1)</p> <p><b><i>In the District of Columbia</i></b></p> <p>In a 199 assessment of the HIV prevention needs of gay APIs in the District of Columbia, 50% of the 27 participants in four focus groups reported that they had engaged in anal sex over the previous six months. Of these, 33% said they never used condoms for anal sex and another 19% said they only used condoms "sometimes." Seventy-four percent of the participants said they never used a condom for oral sex. (3)</p> <p>Decisions made in "the heat of the moment," impaired decision making due to the use of alcohol, and long term relationships in which they developed trust in their partners were given as reasons why condoms were not used. Low self-esteem, shame and guilt were also mentioned as reasons why individuals engage in risky behavior. (3)</p> <p>According to participants in focus groups held in 2002, the rejection and alienation that follows disclosure of their homosexuality may precipitate self-destructive behavior. Their risk is exacerbated by the pervasive perception that API men are less likely to have HIV and are therefore more appealing sexual partners for API and non-API men. Sexual activity is rarely discussed openly in the Asian and Pacific Islander community, so API men often feel uncomfortable asking their partners to wear condoms. (2)</p> <p>A recent survey of gay and bisexual men in the District's Asian and Pacific Islander community revealed that while 78% of the 65 respondents believe that their lives are worth protecting by condom use during sex, 40% believed that if a man suggests use of a condom they are more likely to think he has HIV, and 31% avoid discussing HIV or condom use with their sex partners because it spoils the mood of the sexual encounter. In addition, 28% believed that recreational drug use impairs their judgment about condom use. (2)</p>

Population	Asian and Pacific Islander MSM
Challenges and Obstacles to Prevention (Difficulty Meeting need)	<p>Another study of API gay and bisexual men found that the majority of those who engaged in anal intercourse consumed alcohol and failed to use a condom. (1)</p> <p><b><u>Riskiness of Behavior:</u></b> The CDC has estimated that the risk of unprotected insertive anal sex is 13 times higher than receiving oral sex (ROS) and that unprotected receptive anal sex is 100 times riskier than ROS. Performing oral sex is two times riskier than ROS. Receptive vaginal sex is 20 times higher than receiving oral sex (ROS), the risk of receptive anal sex is 100 times higher than ROS, and the risk of performing oral sex is two times higher than ROS.</p> <p><b><u>Prevalence of Risk Behaviors:</u></b> There are no studies on the prevalence of risk behavior among gay/bisexual men in the District. The San Francisco Prevention Planning Group has estimated that Gay/Bisexual Men engage in unprotected receptive anal intercourse 21 times a year, unprotected insertive anal intercourse 21 times a year. It also estimated that gay/bisexual men received unprotected oral sex 37 times a year and gave unprotected oral sex 9 times a year.</p> <p>Discussions about sexual preferences and behavior that vary from API heterosexual norms are mostly non-existent among API men who have sex with men. In a recent Canadian study, South Asian men exhibited significantly greater levels of homophobia than European MSM.</p> <p>The study established an association between acculturation to the dominant culture's norms and a disinclination by API MSM to partake in risky sexual encounters. The less acculturated API MSM were the more inclined they became to participating in risky sexual behavior. (4)</p> <p>API gays and bisexuals share a characteristic with their Latino counterparts, inadequate familial, communal and peer support mechanisms. Asian and Pacific Islanders are socially and culturally inhibited from openly seeking and acquiring HIV and AIDS prevention and intervention services. (2)</p>
Recurring and Emerging Issues	<p>Because HIV/AIDS among API gay and bisexual men has been relatively low, they are likely to perceive themselves and to be perceived by other MSM as a low risk group for contracting or spreading the disease. This perception coupled with risk taking poses the potential for a future escalation in HIV prevalence among API MSM.</p> <p>According to focus group participants, campaigns designed to target API MSM in the District should show faces of API MSM indicating that the individuals are gay and HIV positive. Some said that the usual inclusion of one API among a sea of many other faces is not enough; the campaign should display many API faces. Some also suggested that the campaign encourage open discussion of HIV/AIDS through town forums, theatrical productions, and community events. (2)</p>

Population	Asian and Pacific Islander MSM
<b>Resources and Gaps</b>	<p>The Resource Inventory identified three HIV prevention programs that target API MSM. One of these programs expects to reach 1,210 API MSM in 2002.</p> <p>Group level interventions and outreach have been shown to be effective in reducing risk behavior in this population. In addition, among young gay and bisexual men in general, outreach, group level interventions and community outreach/community mobilization have shown success.</p> <p>One of the three District programs provides the following types of interventions for this population:</p> <ul style="list-style-type: none"> <li>• group level intervention</li> <li>• outreach</li> <li>• health communications/public information</li> </ul>
<b>Unanswered Questions</b>	<p>Scant data exists about the API gay and bisexual community in the District, especially in light of the diversity of the immigrant population, which includes Filipinos, Koreans and Chinese, both bilingual and monolingual, non-English speakers. There is a need for additional behavioral studies on the risk behaviors of this population, and on the most appropriate interventions for this population.</p>
<b>Sources of Data</b>	<ol style="list-style-type: none"> <li>1. Choi K, Salazar N, Lew S, et. al. AIDS risk, dual identity and community responses among gay Asian and Pacific Islander men. IN: GM Herek, B. Green, eds. AIDS, identity and community: the HIV epidemic and lesbians and gay men. Thousand Oaks, CA: Sage Publications, 1995: 115-134.</li> <li>2. Ogilvy Public Relations Worldwide. Understanding MSM men of colors' attitudes toward HIV education and prevention: A comprehensive research report prepared for: District of Columbia Department of Health, HIV/AIDS Administration. (Draft) May 14, 2002.</li> <li>3. Bourassa V. and Vallabhan S. Assessing the HIV Prevention Needs for Asian and Pacific Islander Gay Men (draft report). Prepared for the Asian and Pacific Islander Partnership for Health. May 1999.</li> <li>4. Bakeman R; Peterson JL. Correlates of high-risk sexual behavior among Canadian men of South Asian and European origin who have sex with men, AIDS Care 2000 Apr 12 (2):193-202.</li> </ol>



<b>Population</b>	<b>Black/African American MSM</b>
<b>Size of Population</b>	<p>11, 365</p> <p>Source: based on a formula proposed by Scott D. Holmberg, MD, MPH in <i>The Estimated Prevalence and Incidence of HIV in 96 Large US Metropolitan Areas</i>, in combination with 2000 US Census Bureau data.</p>
<b>AIDS Incidence: 1996-2001</b>	<p>New AIDS cases: 1,158</p> <p>AIDS Rate: 142 per 10,000 population</p>
<b>General Characteristics of the Population</b>	<p>Black/African American MSM occupy every economic and social strata within the District. Unlike their white and Latino counterparts, they are not clustered into definable neighborhoods but rather live in every neighborhood and Ward throughout the District.</p>
<b>Risk Assessment</b>	<p>A recent study by the Centers for Disease Control and Prevention in six large cities found that the annual incidence of HIV was 4.4 % among gay men 23 to 29 years old of various races and ethnicities. Incidence in this study ranged from 2.5 % among whites, to 3.5% among Latinos and 14.7% among African Americans. The incidence among African American gay men of 14.7%, indicates that for every 100 African American gay men who were not infected at the beginning of the year nearly 15 became infected by the end of the year. (2) The study was conducted in Baltimore, Dallas, Los Angeles, Miami, New York and Seattle in 1998-2000.</p> <p>A survey of Black /African-American MSM indicates that they are more likely to engage in unprotected sexual encounters than their white counterparts., and a larger proportion of men report having multiple sexual partners within the past year. (1)</p> <p>Another CDC study found that Most young gay men in the U.S. are unaware they are infected with HIV. In a report at the 2002 International AIDS Conference in Barcelona, Duncan MacKeller, reported that, of 5,719 young gay men tested in several American cities – Baltimore, Dallas, Los Angeles, New York and Seattle – 573 or about 10% tested positive for HIV. Of those 573 infected individuals, 440 men (77%) were unaware they were infected.</p> <p>MacKeller said that, broken down by ethnic group, 91% of gay or bisexual African-American men were unaware if they were infected, 70% of gay or bisexual Latinos were unaware of their HIV status, and 60% of gay or bisexual whites did not know their HIV status.</p> <p><b><i>In the District of Columbia</i></b></p> <p>During a recent focus group with African American gay men in the District, participants indicated that the risk factors among Black MSM include lack of knowledge, peer pressure, and drinking and drug use, which often impair judgment. They also said that the inundation of HIV</p>

Population	Black/African American MSM
	<p>messages over the past 20 years has desensitized many to the current HIV prevention campaigns. (3)</p> <p>Another major risk group in the District is Black MSM who are engage in sex with both men and women but do not identify themselves as gay or bisexual. This is described as being on the “down low.” They view their lifestyles as separate and distinct from the gay and bisexual culture, so their perceptions of the risks of contracting and spreading HIV may be misguided and underestimated. (3)</p> <p>Nearly a third (32%) of the 105 respondents to a recent survey of African American gay/bisexual men in the District reported that they believe that if a man suggests use of a condom during sex the partner is more likely to think he has AIDS. Similarly, 30% reported that they do not talk about HIV or condoms with their sex partners because it spoils the mood of the encounter</p> <p>Young African-American gay and bisexual men are considered a high at-risk cohort. When asked in a 1999 District focus group if they or their partners had discussed their HIV status before having sex, a majority of young African American MSM said no, even though they were well acquainted with the consequences of participating in risky sexual behavior. They were inclined to indulge in risky sexual behavior once a potential partner said that he was HIV negative. (4)</p> <p>The use of substances and drug use are also factors that place African American MSM at risk for HIV. A recent study found that African American MSM in the Barry Farms section of the District tend to hang out around the drug peddlers and exchange sex for drugs.(5)</p> <p>One community leader said that a number of the young men in Barry Farms have sex with other men, and street intercept interviews revealed that MSM</p> <p>In addition, there are particular “hot spots” in the District like the P street, NW corridor where African American MSM and MSM of other races and ethnic groups engage in consensual but often anonymous, casual, unprotected oral and anal sexual encounters after socializing and drinking alcohol in the areas gay clubs and bars. (5)</p> <p>Overall, it appears that some African American MSM take multiple risks simultaneously, for instance, sharing drug paraphernalia and then engaging in unprotected sexual activities. (4)</p> <p><b><u>Riskiness of Behavior:</u></b> The CDC has estimated that the risk of unprotected insertive anal sex is 13 times higher than receiving oral sex (ROS) and that unprotected receptive anal sex is 100 times riskier than ROS. Performing oral sex is two times riskier than ROS. Receptive vaginal sex is 20 times higher than receiving oral sex (ROS), the risk of receptive anal sex is 100 times higher than ROS, and the risk of performing oral sex is two times higher than ROS.</p> <p><b><u>Prevalence of Risk Behaviors:</u></b> There are no studies on the prevalence</p>

Population	Black/African American MSM
<b>Recurring and Emerging Issues</b>	<p>of risk behavior among gay/bisexual men in the District. The San Francisco Prevention Planning Group has estimated that Gay/Bisexual Men engage in unprotected receptive anal intercourse 21 times a year, unprotected insertive anal intercourse 21 times a year. It also estimated that gay/bisexual men received unprotected oral sex 37 times a year and gave unprotected oral sex 9 times a year.</p> <p>The “down low” category has come to the forefront as a salient issue with implications for HIV transmission between MSM and heterosexual women.</p> <p>District focus group participants said that current ads target primarily gay white men and often omit men of color and particularly men on the down low. According to participants, ads are mainly found downtown and are absent in critical areas like Anacostia and other outlying areas of the District. Participants said an HIV prevention campaign for this population should use a short, simple message; show an African American person; have broad appeal to reach both women and men; and use a variety of mediums including radio, print, and television. (3)</p> <p>Since 1996, mass media campaigns funded by HAA have targeted MSM of color, including African Americans and Latinos. A campaign now under development will target African Americans, Latinos, and Asian/Pacific Islanders.</p>
<b>Resources and Gaps</b>	<p>The Resource Inventory identified five HIV prevention programs that target Black/African American MSM. They expect to reach 7,343 individuals in 2002.</p> <p>Two studies have found that group level interventions are effective in reducing risk behavior among Black MSM, and several studies have found that group-level interventions, outreach, individual level interventions and programs aimed at changing community norms are effective in reducing HIV risk behavior among MSM in general.</p> <p>The five programs that target African American MSM provide the following types of interventions for this population:</p> <ul style="list-style-type: none"> <li>• 3 provide individual level interventions</li> <li>• 5 provide group level interventions</li> <li>• 1 provides prevention case management programs</li> <li>• 5 conduct outreach</li> <li>• 3 provide health communications/public information</li> </ul>
<b>Unanswered Questions</b>	<p>There is a need for behavioral studies on the risk behaviors of this population, including MSM from Africa and the Caribbean, and on the most appropriate interventions. In 2001, HAA funded Us Helping Us to conduct a study of risk behavior among African American gay and bisexual men.</p>

Population	Black/African American MSM
<b>Sources of Data</b>	<ol style="list-style-type: none"> <li>1. Myers HF; Satz P; Miller BE; Bing EG; Evans G; Richardson MS, Forney D, Morgenstern H; Saxton E; D'Elia L; Longshore D; Mena I: The African-American Health Project (AAHP); Study disorders in African-American men. <i>Ethn Health</i>. 199, Aug 2(3): 183-196</li> <li>2. Carns A. HIV Study shows 4.4% infection rate for gay men, especially Blacks. <i>Wall Street Journal</i>, June 1, 2001.</li> <li>3. Ogilvy Public Relations Worldwide. Understanding MSM men of colors' attitudes toward HIV education and prevention: A comprehensive research report prepared for: District of Columbia Department of Health, HIV/AIDS Administration. (Draft) May 14, 2002</li> <li>4. District of Columbia Department of Health, HIV/AIDS Administration. HIV Prevention Plan/Population Specific Prevention Needs Report, 2001</li> <li>5. District of Columbia Department of Health, HIV/AIDS Administration, Report on the Rapid Assessment of HIV Prevention and Care in Four Washington, D.C. Neighborhoods. October 2001</li> <li>6. Thomas SB; Quinn SC. The Tuskegee Syphilis Study 1932 to 1972: Implications for HIV education and AIDS risk reduction programs in the African American community. <i>American Journal of Public Health</i>. 1991; 81: 1498-1506.</li> <li>7. Eng TR, Butler WT, eds. <i>The Hidden Epidemic: Confronting Sexually Transmitted Diseases</i>, Washington, D.C.: National Academy Press; 1996.</li> </ol>

<b>Population</b>	<b>Latino MSM</b>
<b>Size of Population</b>	<p>1, 496</p> <p>Source: based on a formula proposed by Scott D. Holmberg, MD, MPH in <i>The Estimated Prevalence and Incidence of HIV in 96 Large US Metropolitan Areas</i>, in combination with 2000 US Census Bureau data.</p>
<b>AIDS Incidence: 1996-2001</b>	<p>New AIDS Cases: 89</p> <p>AIDS Rate: 74 per 10,000 population</p>
<b>General Characteristics of the Population</b>	<p>Latino MSM are found primarily in three District neighborhoods: Mount Pleasant, Columbia Heights and Petworth. The largest group of Latinos in the District, including Latino MSM, comes from Central American countries such as El Salvador, Guatemala, Honduras and Nicaragua. (3)</p> <p>The 11,741 Salvadorans living in the District in 2000 make up the largest group of Latinos in the District, which had 44,953 Latino residents in 2000, according to the U.S. Census. Central Americans make up 35% of the District's Latino population.</p> <p>After Salvadorans, the next largest groups of Latinos by country of origin were Mexicans (5,098 or 11%); Puerto Ricans (2,328 or 5%); Dominicans (1,496 or 3%); Guatemalans (1,350 or 3%); Cubans (1,101 or 2%); Colombians (859 or 2%); and Hondurans (853 or 2%).</p>
<b>Risk Assessment</b>	<p>An assessment of the HIV prevention needs of gay/bisexual Latino men in the District, conducted in 1996, found that while there was a high level of knowledge about how HIV is transmitted and most individuals knew what to do to reduce the risk of HIV transmission, individuals did not always recognize high risk behavior when they engaged in it. (1)</p> <p>This finding was echoed by a participant in a DC focus group for gay/bisexual Latino men, held in August 1998, in which one participant stated: "People know what to do to protect themselves; they just do not do it."(2)</p> <p>Forty-six percent of study participants indicated that they engaged in anal sex, and of those that engaged in anal sex approximately 25% did not use a condom every time. (1)</p> <p>Self-perception of risk in this population was not measured by the risk of the behavior, but by an individual's perception of his prospective partner's serostatus. Those that did not use condoms every time cited the influence of their sexual partner as the most common reason for this failure.</p> <p>Participants in the focus group identified cultural characteristics in the Latino gay community that may be barriers to safe sex practices and the dissemination of prevention information. The men perceived the</p>

Population	Latino MSM
	<p>Hispanic/Latino gay community to be “closed.” Gay “lifestyle,” particularly sex, is not openly discussed, and most safe sex information seems to filter in from the heterosexual information that is out on the street. (2)</p> <p>A recent survey of 78 gay and bisexual Latinos in the District found that 53 % of respondents believe if a man suggests use of a condom during sex they are more likely to think he has HIV. Twenty five percent said that they do not talk about HIV or condoms with their sex partners because they feel their partners will think they have HIV and 21% avoid discussion of HIV or condoms because it negatively affects the mood of the encounter. (3)</p> <p>Young immigrant men sometimes resort to sex work or "survival sex." Recent interviews with Latino representatives revealed the commonality of young Latino males being solicited for sex by older often white or African American men, particularly in the Mount Pleasant area. (4)</p> <p>A study of four communities in the District revealed that in some instances drinking, drug use and risky sexual activity among MSM occurs during after hour parties called “chiviadas” that commence after area bars close. (5)</p> <p>Unprotected oral and anal sex was notably common among Latino MSM who frequented P Street NW between 21<sup>st</sup> and 23<sup>rd</sup> Streets because the sexual openness and freedom of the area are tantalizing to those who have experienced the repression of homosexual activity that characterizes their countries of origin. (5)</p> <p>An entrenched cultural aversion to homosexuality appears to be a major factor in getting the prevention message across. Latino men are less likely to discuss matters of a sexual nature regardless of their orientation. This, coupled with the frequent use of drugs and alcohol by young, jobless and sometimes homeless men can complicate addressing HIV and AIDS. Cultural, language, literacy and ethnic differences limit the amount and type of prevention messages available to Latino MSM. Central American gay and bisexual men have few ethnically relevant prevention images or messages with which to identify. (6)</p> <p>A recent study by the Centers for Disease Control and Prevention in six large cities found that the annual incidence of HIV was 4.4 % among t gay men 23 to 29 years old of various races and ethnicities. Incidence in this study ranged from 2.5 % among whites, to 3.5% among Latinos and 14.7% among African Americans. The study was conducted in Baltimore, Dallas, Los Angeles, Miami, New York and Seattle in 1998-2000. (7)</p> <p>Another CDC study found that Most young gay men in the U.S. are unaware they are infected with HIV. In a report at the 2002 International AIDS Conference in Barcelona, Duncan MacKeller, reported that of 5,719 young gay men tested in several American cities – Baltimore, Dallas, Los Angeles, New York and Seattle – 573 or about 10% of them tested positive for HIV. Of those 573 infected individuals, 440 men or 77</p>

Population	Latino MSM
	<p>percent were unaware they were infected.</p> <p>MacKeller said that, broken down by ethnic group, 91% of gay or bisexual African-American men were unaware if they were infected, 70% of gay or bisexual Latinos were unaware of their HIV status and 60% of gay or bisexual whites did not know whether they had the disease.</p> <p>According to a study conducted in the Washington metropolitan area by La Clínica del Pueblo and Identity, low self-esteem, disempowerment, childhood sexual abuse, cultural isolation and stigmatization, and real and perceived violence also heighten the potential for destructive behavior. High poverty levels, discrimination and rejection place Latino MSM at greater risk of infection. (6)</p> <p>Familismo, a traditional Latino commitment to family and a central support to family members, can be a powerful incentive in helping heterosexual Latino men reduce unprotected sex with casual partners outside of primary partnerships. However, for many Latino MSM, familismo and homophobia can create conflict because families may perceive homosexuality as wrong. MSM are forced to separate their sexual identity from their family life, leading to low self-esteem and personal shame. (9)</p> <p>A multisite study of Latino gay men in the U.S., conducted between 1998 and 1999, examined the relationship between the increased risk of HIV and social factors of homophobia, racism and financial hardship. Among the probability sample of 912 Latino gay men, those who reported unprotected anal intercourse with a non-monogamous recent partner were compared with men who did not report that behavior. Findings were consistent with the hypotheses that during their childhood and adulthood men in the high-risk group were significantly more likely to have experienced various forms of homophobia and racism as well as circumstances of extreme financial hardship. (8)</p> <p><b><u>Riskiness of Behavior:</u></b> The CDC has estimated that the risk of unprotected insertive anal sex is 13 times higher than receiving oral sex (ROS) and that unprotected receptive anal sex is 100 times riskier than ROS. Performing oral sex is two times riskier than ROS. The risk of performing unprotected oral sex is two times higher than ROS.</p> <p><b><u>Prevalence of Risk Behaviors:</u></b> There are no studies on the prevalence of risk behavior among gay/bisexual men in the District. The San Francisco Prevention Planning Group has estimated that Gay/Bisexual Men engage in unprotected receptive anal intercourse 21 times a year, unprotected insertive anal intercourse 21 times a year. It also estimated that gay/bisexual men received unprotected oral sex 37 times a year and gave unprotected oral sex 9 times a year.</p>
<b>Challenges and Obstacles to Prevention</b>	<p>An entrenched cultural aversion to homosexuality appears to be a major factor in getting the prevention message across. Latino men are less likely to discuss matters of a sexual nature regardless of their orientation.</p>

<b>Population</b>	<b>Latino MSM</b>
<b>(Difficulty Meeting need)</b>	<p>Cultural, language, literacy and ethnic differences limit the amount and type of prevention messages available to Latino MSM. Central American gay and bisexual men have few ethnically relevant prevention images or messages to with which to identify. (6)</p> <p>Late entry into care or the lack of health care is also common. During a focus group of Latino gay, bisexual and transgendered men, support services were rarely acknowledged. When mentioned, the context was most often a crisis situation or following risky sexual activity. (6)</p> <p>A representative of a clinic in the District noted that in many instances HIV positive Latinos, especially recent immigrants, fail to access health care until they are in the late stages of full blown AIDS.(7) The clinic del Pueblo serves under and uninsured Latinos and provides HIV prevention services for Latino MSM in the District of Columbia metro area.</p>
<b>Resources and Gaps</b>	<p>The Resource Inventory identified four HIV prevention programs that target Latino MSM. They expect to reach 2,301 men in 2002.</p> <p>The four programs that include Latino MSM as a focus for prevention efforts provide the following types of interventions for this population.</p> <ul style="list-style-type: none"> <li>• individual level interventions</li> <li>• group level interventions</li> <li>• prevention case management programs</li> <li>• outreach</li> <li>• health communications/public information</li> </ul>
<b>Unanswered Questions</b>	<p>Evaluations of existing campaigns and prevention strategies and further investigation of cultural and linguistic factors that directly address the needs of, particularly new immigrant, Latino MSM are needed. In addition, further research is needed to identify the causes of underutilization of health and human services by MSM.</p>
<b>Sources of Data</b>	<ol style="list-style-type: none"> <li>1. Assessment of the HIV Prevention Needs of Gay/Bisexual Latino Men in the District of Columbia. Salud, Inc., 1996</li> <li>2. Focus Group Report, DC Public Benefits Corporation, September 1998.</li> <li>3. Ogilvy Public Relations Worldwide. Understanding MSM men of colors' attitudes toward HIV education and prevention: A comprehensive research report prepared for: District of Columbia Department of Health, HIV/AIDS Administration. (Draft) May 14, 2002.</li> <li>4. District of Columbia HIV Prevention Community Planning Group. Community Consultation on immigrants. April 2002.</li> <li>5. District of Columbia Department of Health, HIV/AIDS Administration, Report on the Rapid Assessment of HIV Prevention and Care in Four Washington, D.C. Neighborhoods. October 2001</li> </ol>



Population	Latino MSM
	<ol style="list-style-type: none"> <li data-bbox="477 262 1281 352">6. Response to RFA #1019-01, Program Area II, Community-Level Interventions Proposal, Submitted by La Clínica del Pueblo, Inc. to the District of Columbia's Department of Health.</li> <li data-bbox="477 369 1281 428">7. Carns A. HIV Study shows 4.4% infection rate for gay men, especially Blacks. Wall Street Journal, June 1, 2001.</li> <li data-bbox="477 445 1317 535">8. Díaz R. and Ayala G. Social discrimination and health: The case of Latino gay men and HIV risk. The Policy Institute of the National Gay and Lesbian Task Force: New York. 2001.</li> <li data-bbox="477 552 1330 609">9. Díaz RM. Latino Gay Men and HIV: Culture, Sexuality and Risk Behavior. New York: Routledge Press, 1998.</li> </ol>

<b>Population</b>	<b>White MSM</b>
<b>Size of Population</b>	<p>5, 682</p> <p>Source: based on a formula proposed by Scott D. Holmberg, MD, MPH in <i>The Estimated Prevalence and Incidence of HIV in 96 Large US Metropolitan Areas</i>, in combination with 2000 US Census Bureau data.</p>
<b>AIDS Incidence: 1996-2001</b>	<p>New AIDS Cases: 415</p> <p>AIDS Rate: 55 per 10,000 population</p>
<b>Risk Assessment</b>	<p>Only 51% of participants in a 2001 study of white MSM in the District reported that they used condoms always or 50% of the time when they were receptive partners during anal intercourse in an ongoing relationship. Less than two-thirds said that they used condoms when they were the insertive partners. For non-monogamous relationships, the percentage of condom users rose slightly to three-fourths of respondents. (1)</p> <p>Seventy-nine percent of survey respondents indicated that they had casual sex with men other than their committed partners in the past 12 months. One-fifth (21%) of respondents felt that they placed both themselves and their partners at-risk for HIV. (1)</p> <p>Among the 86 HIV-positive respondents, 73% reported involvement in an ongoing sexual relationship in the past year. More than two-thirds of respondents involved in ongoing sexual relationships said they used condoms always (49%) or more than half of the time (18%) as the receptive partner during anal sex, while more than three-fourths said they used condoms always (64%) or more than half of the time (13%) as the insertive partner. However, condom use during oral sex was low: 84% of respondents said they never (77%) or seldom (7%) used condoms when they were the receivers of oral sex and 95% of respondents reported they never (85%) or seldom (10%) used condoms when performing oral sex on their partners. (1)</p> <p>Among the 86 HIV-positive respondents, 85% reported involvement in casual sexual relationships over the past 12 months. Of the HIV-positive men who participated in casual sexual relationships, 43% said they always used condoms and 28% said they used condoms more than half the time during anal sex as the receptive partner. In the same group, 46% of respondents said they always used condoms and 29% said they used condoms more than half the time as the insertive partner. In contrast, during oral sex, 91% of HIV-positive men in casual relationships said they never (78%) or seldom (13%) used condoms when they were receivers of oral sex and 93% indicated that they never (75%) or seldom (18%) used condoms when performing oral sex on their partners. (1)</p> <p>Two thirds of survey respondents engaged in anal and oral sex while under the influence of alcohol and drugs. (1) Young white MSM ages 22 to 25 consider alcohol to be a significant component in their sexual</p>

Population	White MSM
	<p>encounters.</p> <p>The P Street, NW corridor of the District is home to numerous gay bars and clubs and after periods of socializing and drinking alcohol, white MSM and MSM of other races and ethnic groups sometimes engage in unprotected oral and anal sex. (3)</p> <p>Survey respondents overwhelmingly indicated that alcohol was their favorite drug of choice, followed by speed and poppers (amyl nitrate), marijuana and ecstasy. Crack and heroin are also used. (1)</p> <p>Between 1998 and 2000, the Centers for Disease Control and Prevention in Atlanta conducted a survey of gay men in six large cities – Baltimore, Dallas, Los Angeles, Miami, New York and Seattle – involving 2,942 respondents ages 23 to 29 of various races and ethnicities. The annual incidence of HIV was 4.4 % among these young gay men, a finding comparable to rates among gay men in the 1980s, the early years of the AIDS epidemic, and to current rates among sexually active adults in South Africa. Incidence in this study ranged from 2.5 % among whites, to 3.5% among Latinos and 14.7% among African Americans. The incidence among white gay males indicates that for every 100 white gay men who were not infected at the beginning of the year between two and three became infected by the end of the year. (2)</p> <p><b><u>Riskiness of Behavior:</u></b> According to findings from the Whitman Walker study, about a quarter of white MSM surveyed seldom or never uses condoms when engaging in non-monogamous sexual intercourse. The CDC has estimated that the risk of unprotected receptive anal sex is 100 times receiving oral sex (ROS), the risky of insertive anal sex is 13 times higher than ROS, and the risk of performing oral sex is 2 times higher than ROS.</p> <p><b><u>Prevalence of Risk Behaviors</u></b> There are no studies on the prevalence of risk behavior in the District. The San Francisco Prevention Planning Group has estimated that gay/bisexual men engage in unprotected receptive anal intercourse and unprotected insertive anal intercourse 21 times a year, they engage in unprotected receptive oral sex 37 times a year and they perform oral sex 9 times a year.</p> <p><b><u>Multiple Risk Factors:</u></b> About two thirds of respondents in the Whitman Walker study reported that they engaged in anal and oral sex while under the influence of drugs or alcohol.</p>
<b>Recurring and Emerging Issues</b>	<p>The new generation of young white MSM is seemingly more likely to be influenced by drug and alcohol use and willing to risk HIV exposure. Since the onset of the AIDS epidemic, white gay and bisexual men have been inundated with prevention messages of every kind. In many instances, their magnitude and frequency has had the opposite of the intended effect on the targeted population. (4)</p>
<b>Resources and Gaps</b>	<p>The resource inventory identified one HIV prevention program that targets white gay/bisexual men. It expects to reach 3,120 white MSM in</p>

Population	White MSM
<b>Unanswered Questions</b>	<p>2002.</p> <p>Among the MSM population in general, strategies with demonstrated success include group and individual level interventions, outreach, and health communications /public information. In addition, among young gay and bisexual men, outreach, group level interventions and community outreach/community mobilization have shown success.</p> <p>They provide the following types of interventions for this population.</p> <ul style="list-style-type: none"> <li>• individual level interventions</li> <li>• group level interventions</li> <li>• prevention case management</li> <li>• outreach interventions</li> <li>• health communications/public information</li> </ul> <p>There is a need for additional behavioral studies on why white MSM engage in risk behaviors, and on the most appropriate interventions for this population.</p>
<b>Sources of Data</b>	<ol style="list-style-type: none"> <li>1. District of Columbia Department of Health, HIV/AIDS Administration and Whitman Walker Clinic, Men Who Have Sex With Men (MSM) Survey Results 2001.</li> <li>2. Carns A. HIV Study shows 4.4% infection rate for gay men, especially Blacks. Wall Street Journal, June 1, 2001.</li> <li>3. District of Columbia Department of Health, HIV/AIDS Administration, Report on the Rapid Assessment of HIV Prevention and Care in Four Washington, D.C. Neighborhoods. October 2001.</li> <li>4. DC Public Benefits Corporation, Focus Group Report, September 1998.</li> </ol>

Population	MSM who are also Injecting Drug Users (MSM/IDUs)
<b>Size of Population</b>	Unknown
<b>AIDS Incidence: 1996-2001</b>	<p>New AIDS cases: 117</p> <p>AIDS Rate: Unknown</p> <p>Among men who have sex with men who are also intravenous drug users in the District, the number of AIDS cases has declined from 48 in 1991 to 11 cases in 2001. The number of cases has fallen in the 10-year period but the percentage of cases has actually been gradually increasing. (1) Although the number of new cases among Black MSM/IDU has fallen, the decrease does not equal the decrease that is occurring among other racial groups and exposure categories, including White MSM/IDU.</p>
<b>Risk Assessment</b>	<p>Men who have sex with men and inject drugs pose unique challenges for HIV risk reduction efforts because they have multiple risks for HIV acquisition and transmission. Interviews of MSM/IDUs who had AIDS diagnosed from 1996 to 1998 in 12 states found that 1) over half were non-Hispanic blacks and Hispanics, and most were from large metropolitan statistical areas; 2) AIDS incidence has declined since 1996; and 3) a high prevalence of drug-related and sexual risk behaviors occurred among MSM/IDUs with AIDS. (2)</p> <p>Nationally, the proportion of all AIDS cases among MSM/IDU decreased from 8% in 1990 to 5% in 1998; 2,161 MSM/IDU had AIDS diagnosed in 1998, and 18,133 MSM/IDU were living with AIDS as of December 1998.</p> <p>The 513 MSM/IDUs who had AIDS diagnosed during 1996-1998 were interviewed for the project. had high rates of high-risk sexual and drug-related risk behaviors. Eighty-two percent of MSM/IDUs had ever used non-injecting drugs, and 61% of MSM/IDUs had used crack cocaine.</p> <p>Of those injecting drugs during the 5 years preceding the interview, 45% had shared needles.</p> <p>Seventy-six percent of MSM/IDU had sex with men during the 5 years preceding the interview, and 43% had sex with women.</p> <p>Nearly half of those who had sex during the year preceding the interview did not always use condoms. However, consistent condom use was higher when the steady sex partner was known to be uninfected: 61% who had vaginal intercourse, 57% who had insertive anal intercourse with a man, and 61% who had receptive anal intercourse with a man during the year preceding the interview said that they had always used condoms.</p> <p>During the 5 years preceding interview, 18% to 20% of MSM/IDUs exchanged sex for money or drugs.</p> <p>The interview information in a sample of MSM/IDUs with AIDS</p>

Population	MSM who are also Injecting Drug Users (MSM/IDUs)
	<p>indicates a high prevalence of drug-related and sexual risk behaviors, including sex with men and women. Previous studies have reported similar findings (3,4).</p> <p>Non-Hispanic black and Hispanic men were over-represented among MSM/IDUs, accounting for half of MSM/IDUs living with AIDS but 22% of the general male population. Race/ethnicity is not a risk factor for HIV infection; social and economic factors associated with race/ethnicity, such as high poverty rates and unemployment and lack of access to health care, are associated with high rates of risk behavior (5).</p> <p>Of 85 MSM/IDUs interviewed in a study in Denver, Colorado, 46% reported to have been high on drugs for half or more of their sexual encounters. The men in the study had sex with men and injected drugs within the past six months (6)</p> <p>Cocaine was preferred by 29% and methamphetamines by 20% as the drug of choice for "partying", while 40% identified cocaine and 34% methamphetamines as the drug of choice for having sex: heroin was not cited as a preferred drug for either of these activities.</p> <p>Over half (57%) of the men indicated that sex used to be most important to them and they used drugs to enhance the experience; only 35% of the sample indicated that this was still the case. Conversely, 34% of the sample indicated that drugs used to take priority over sex, or they always combined the two, and almost half of the sample (48%) described their current perspective on the relationship between sex and drugs in this manner.</p>
<b>Risk Assessment</b>	<p>Because MSM/IDUs have multiple risks for HIV infection, they are particularly vulnerable to infection and can transmit HIV across multiple populations, including MSM, IDU, and heterosexual women. (1)</p> <p>In the Denver study, Men most frequently indicated that they utilized condoms less while high with non-main male partners; 43% of these men suggest that while they are high they forget about condoms, and 36% state drugs allow them to overcome the guilt they would feel for not using condoms. (6)</p>
<b>Resources and Gaps</b>	<p>Prevention strategies must provide the information, skills, and support necessary to reduce both sexual and drug-related risk behaviors among MSM/IDU, and include access to drug treatment and to prevention case management.</p> <p>No programs in the District target this population.</p>
<b>Need for Additional Studies</b>	<p>Additional research is needed to determine whether risk reduction strategies that have been effective for groups with single risks also are effective for groups with multiple risks. HIV disease surveillance supplemented with behavioral surveys will help in planning prevention, treatment, and other services needed to reduce transmission and to</p>

Population	MSM who are also Injecting Drug Users (MSM/IDUs)
Sources of Data	<p>improve survival and quality of life for infected persons. (1)</p> <ol style="list-style-type: none"> <li>1. Epidemiologic Profile of the District of Columbia, HIV/AIDS Administration, 2002.</li> <li>2. Centers for Disease Control and Prevention, <i>HIV/AIDS Among Men Who Have Sex With Men and Inject Drugs --- United States, 1985--1998</i>, Morbidity and Mortality Weekly Report, June 02, 2000 / 49(21);465-470.</li> <li>3. CDC. HIV risk practices of male injecting-drug users who have sex with men---Dallas, Denver, and Long Beach, 1991--1994. MMWR 1995;44:767-9.</li> <li>4. Sullivan PS, Nakashima AK, Purcell D, Ward JW, and the Supplement to HIV/AIDS Surveillance Study Group. Geographic differences in non-injection and injection substance use among HIV-seropositive men who have sex with men: western United States versus other regions. J Acquir Immune Defic Syndr Hum Retrovirol 1998;19:266--73.</li> <li>5. National Commission on AIDS. The challenge of HIV/AIDS in communities of color. Washington, DC: National Commission on AIDS, December 1992.</li> <li>6. Bull S; Piper P; Rietmeijer C; Denver Public Health, CO, USA. <i>The relationship between sex, drugs, and condom use among men who have sex with men and also inject drugs (MSM-IDU) in Denver</i>. Int Conf</li> </ol>

Population	Mentally Ill / Individuals with Persistent Mental Illness
<b>Size of Population</b>	<p data-bbox="479 281 873 308"><b>26,250</b> (Range: 18, 123 – 34,776)</p> <p data-bbox="479 348 1307 478">Source: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 1990 estimate of the number of persons 18 and older with serious mental illness by State. The estimate does not include persons who are homeless or institutionalized</p> <p data-bbox="479 533 1192 560"><b>Proportion of Youth 9 to 17 with Emotional Disturbance:</b></p> <ul data-bbox="527 583 1274 783" style="list-style-type: none"> <li data-bbox="527 583 1073 611">• Youth with any diagnosable disorder: 20%</li> <li data-bbox="527 634 1274 699">• Youth with a serious emotional disturbance with substantial functional impairment: 9% to 13%</li> <li data-bbox="527 722 1243 783">• Youth with a serious emotional disturbance with extreme functional impairment: 5% to 9%</li> </ul> <p data-bbox="479 806 1323 936">Source: Fridman, R.M.; Katz-Levy, J.W.; Manderscheid, R.W., and Sondheim, D.L. Prevalence of serious emotional disturbance: An Update. <i>Mental Health, United States, 1996</i>. DHHS Publication number (SMA) 96-3098.</p> <p data-bbox="479 972 1304 1066">According to the Substance Abuse and Mental Health Services Administration, the District contains "one of the largest populations of deaf persons with mental illness in the country."</p>
<b>AIDS Incidence: 1996-2001</b>	<p data-bbox="479 1106 602 1134"><b>Unknown</b></p> <p data-bbox="479 1171 1281 1236">Nationally, HIV seroprevalence among the seriously mentally ill has been estimated at 6%. (10)</p>
<b>General Characteristics of the Population</b>	<p data-bbox="479 1276 1323 1539">Persons with serious mental disorders include persons with schizophrenia, major depression and manic-depressive or bipolar illness, and obsessive-compulsive disorder and panic disorder. Schizophrenia follows a long-term course with symptoms varying in the degree of severity. Affective disorders include major depression and manic-depressive illness. Anxiety disorders, which are more common than any other mental health condition, include panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder, and phobia.(1)</p> <ul data-bbox="479 1562 1323 1883" style="list-style-type: none"> <li data-bbox="479 1562 1323 1627">• About 6.5% of women, and 3.3% of men will have major depression in any year. (2)</li> <li data-bbox="479 1650 1281 1715">• Manic-depressive illness affects around 1 percent of adults, with rates almost equal across women and men. (2)</li> <li data-bbox="479 1738 1323 1803">• Mental disorders differ in how they are manifested by gender, racial and ethnic group, and age. For example,</li> <li data-bbox="479 1827 1291 1883">• Major depression affects approximately twice as many women as men.(3, 4)</li> </ul>



Population	Mentally Ill / Individuals with Persistent Mental Illness
	<ul style="list-style-type: none"> <li>• Women who are poor, on welfare or are unemployed are more likely to experience depression than women in the general population. (3, 4)</li> <li>• Anxiety, panic, and phobic disorders affect two to three times as many women as men. (5, 6, 7)</li> <li>• Depression rates are much higher among older Americans who experience a physical health problem (4)</li> <li>• Addictive disorders frequently co-occur with mental health disorders:</li> <li>• Among adults aged 18 years and older with a lifetime history of any mental disorder, 29% have a history of an addictive disorder; (4)</li> <li>• Of those with an alcohol disorder, 37% have had a mental disorder; and (4)</li> <li>• Among those with other drug disorders, 53% have had a mental disorder. (4)</li> </ul> <p>Having both mental and addictive disorders within the same year is a particularly significant clinical treatment issue, complicating treatment for each disorder. About 3% of the population aged 18 years and older has been identified as having co-occurring mental and addictive disorders in one year.</p> <ul style="list-style-type: none"> <li>• Of those with a serious mental illness, 15% have both types of disorder in one year, (8)</li> <li>• Of those with a severe and persistent mental illness, 27% have both mental and addictive disorders. (7)</li> <li>• Co-occurring, or comorbid, mental and addictive disorders are estimated to affect 50% to 60% of homeless persons. (8)</li> <li>• Comorbid mental and addictive disorders also are evident in children and adolescents. (9)</li> </ul>
Risk Assessment	<p>Chronic mentally ill adults living in the community have a high risk for HIV infection associated with a number of risk behaviors. Impulsivity, high levels of sexual activity during acute exacerbations of psychiatric illness, poor skills at negotiating safe sex, homelessness and drug abuse are all risk behaviors common among those affected by some mental illnesses. (11)</p> <p>HIV risk levels for this population have also been associated with demographic factors, diagnosis, symptom severity, trauma history, post-traumatic stress disorder, substance use disorder and sexual orientation. (14)</p> <p>A survey and testing of outpatient and inpatient admission to a Maryland</p>

Population	Mentally Ill / Individuals with Persistent Mental Illness
<b>Challenges and Obstacles to Prevention (Difficulty Meeting need)</b>	<p>state psychiatric hospital between August 1990 and July 1991 found that 31 patients or 5.8% of 533 patients surveyed were infected with HIV. (13) The vast majority of patients (90%) reported no knowledge of their HIV status on admission to the hospital and 4.1% of these patients were infected with HIV. These findings are suggestive of prevalence of HIV risk within this population and underscore the importance of targeted risk reduction programs.</p> <p>A behavioral study of the chronically mentally in Wisconsin found unprotected sex frequently associated with substance use; coerced sex; bartering sex for money, food, clothes, or a place to stay; and sex with injecting drug user partners. Factors predictive of greater risk were being female, presently being in a relationship, perceiving oneself to be at risk, high levels of alcohol use, and weak risk reduction behavioral intentions. (15)</p> <p>Bipolar disorder and perhaps schizophrenia are related to increased HIV risk, and persons in whom both Axis I and Axis II disorders are diagnosed appear to be at greater HIV behavioral risk. (16)</p> <p><b><u>Prevalence of Risk Behaviors:</u></b> Unknown.</p> <p>Mental illness itself is generally the first barrier to intervention. The co-existence of other behavioral health problems (e.g. substance abuse) increase opportunities for impaired judgement and high-risk behaviors. Barriers and obstacles to prevention with the population of mentally ill begin with the illnesses. (15)</p> <p>Cultural differences and perceptions may result in some populations being less likely to seek care. Persons who do not have sufficient social supports are also at risk and can be found among the city's homeless population. (17) Gender differences in risk highlight the importance of focusing on gender issues when delivering HIV prevention interventions to men and women who are severely mentally ill. (15)</p>
<b>Recurring and Emerging Issues</b>	<p>Mental disabilities resulting from advanced stages of AIDS may impair the judgement of Persons Living with AIDS leading to high risk behaviors – substance abuse, unprotected sexual activity. May also place persons in situations in which others may take advantage of them sexually.</p>
<b>Resources and Gaps</b>	<p>The Resource Inventory identified six HIV prevention programs that target this population. They expect to reach 621 individuals in 2002.</p> <p>Small-group interventions that focus on sexual communication, condom use skills and motivation to practice safer sex have been shown to be effective at helping mentally ill persons reduce their risk for HIV. Substance abuse prevention and treatment may be the most effective means of reducing HIV risk in this population. (11)</p> <p>In 1993, CDC awarded grants for the development, implementation and</p>

Population	Mentally Ill / Individuals with Persistent Mental Illness
<b>Need for Additional Studies</b>	<p>evaluation of HIV education material and curricula that would be acceptable and accessible to persons with disabilities. However, no studies have been reported on the extent to which the strategies have increased knowledge or affected any risk reduction behavior change. (12)</p> <p>There is a need for studies on the risk behaviors of individuals with mental illness and on the most appropriate interventions for this population.</p>
<b>Sources of Data</b>	<ol style="list-style-type: none"> <li>1. National Advisory Mental Health Council. Health care reform for Americans with severe mental illnesses: Report of the National Advisory Mental Health Council. <i>American Journal of Psychiatry</i> 150:1447-1465, 1993.</li> <li>2. Robins, L.N.; Locke, B.Z.; and Regier, D.A. An overview of psychiatric disorders in America. In: Robins, L.N., and Regier, D.A. (eds.). <i>Psychiatric Disorders in America: The Epidemiologic Catchment Area Study</i>. New York, NY: Free Press, 1991.</li> <li>3. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration and National Institutes of Health. <i>Mental Health: A Report of the Surgeon General</i>, 1999.</li> <li>4. Weissman, M.M., and Klerman, J.K. Depression: Current understanding and changing trends. <i>Annual Review of Public Health</i> 13:319-339, 1992.</li> <li>5. American Psychiatric Association. Practice guidelines for the treatment of patients with panic disorder. <i>American Journal of Psychiatry</i> 155(suppl.12):1-34, 1998.</li> <li>6. Brawman-Mintzer, O., and Lydiard, R.B. Generalized anxiety disorder: Issues in epidemiology. <i>Journal of Clinical Psychiatry</i> 57(suppl.7):3-8, 1996.</li> <li>7. Regier, D.A.; Farmer, M.E.; Rae, D.S.; Myers, J.K.; Kramer, M.; Robins, L.N.; George, L.K.; Karno, M.; and Locke, B.Z. One-month prevalence of mental disorders in the United States and sociodemographic characteristics: the Epidemiologic Catchment Area study. <i>Acta Psychiatrica Scandinavica</i> 88, 35-47, 1993.</li> <li>8. Kessler, R.C.; Berglund, P.A.; Zhao, S.; et al. The 12-month prevalence and correlates of serious mental illness. In: <i>Mental Health, United States, 1996</i>. (DHHS Publication No. (SMA) 96-3098). Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 1996.</li> <li>9. Interagency Council on the Homeless. <i>Outcasts on Main Street</i>. HHS Pub. No. ADM 92-1904. Rockville MD: Alcohol, Drug Abuse, and Mental Health Services Administration, 1992.</li> <li>10. Kessler, R.C.; Nelson, C.B.; McGonagle, K.A.; et al. The epidemiology of co-occurring addictive and mental disorders: Implications for prevention and service utilization. <i>American Journal of Orthopsychiatry</i> 66:21-23, 1996.</li> <li>11. Pinkerton SD, Johnson-Masotti AP, Otto-Salaj LL, Stevenson LY,</li> </ol>

Population	Mentally Ill / Individuals with Persistent Mental Illness
	<p>Hoffmann RG. Cost-effectiveness of an HIV prevention intervention for mentally ill adults. <i>Ment Health Serv Res</i> 2001 Mar;3(1):45-55</p> <p>12. Rahav M, Nuttbrock L, Rivera JJ, Link BG. (1998) HIV infection risks among homeless, mentally ill, chemical misusing men. <i>Subst Use Misuse</i>. 33(6):1407-26.</p> <p>13. Stewart DL; Zuckerman CJ; Ingle JM. HIV seroprevalence in a chronically mentally ill population. <i>J Natl Med Assoc</i>. 1994 Jul;86(7): 519-23.</p> <p>14. Otto-Salaj LL, Heckman TG, Stevenson LY, Kelly JA. Patterns, predictors and gender differences in HIV risk among severely mentally ill men and women 1: <i>Community Ment Health J</i> 1998 Apr;34(2):175-90</p> <p>15. Otto-Salaj LL, Kelly JA, Stevenson LY, Hoffmann R, Kalichman SC. Outcomes of a randomized small-group HIV prevention intervention trial for people with serious mental illness. 4: <i>Community Ment Health J</i> 2001 Apr;37(2):123-44</p> <p>16. HPCPG Community Consultation with providers of services to IDUs, Substance Abusers, the Homeless and the Mentally Ill, May 2002</p> <p>17. Otto-Salaj LL, Stevenson LY (2001). Influence of psychiatric diagnoses and symptoms on HIV risk behavior in adults with serious mental illness. <u><i>AIDS Read</i></u>, 11(4):197-204, 206-8</p>

Population	Older Adults (50 years and older)
Size of Population	<p>118,369</p> <p>2000 Census</p>
AIDS Incidence: 1996-2001	<p>New AIDS cases: 570</p> <p>AIDS rate: 58 per 10,000 population</p>
Risk Assessment	<p>Few persons over the age of 50 at risk for HIV routinely get tested. Many older adults are first diagnosed with HIV at a late stage of infection when they seek treatment for an HIV-related illness. (1)</p> <p>The National Institutes of Health estimates that persons 50 and older account for about 11% of all known AIDS cases and, while the number of AIDS cases reported annually among young persons are declining, there is an increase among older adults. (2) In the last few years, new AIDS cases rose faster in middle age and older people than in people under 40. While many of these AIDS cases are the result of HIV infection at a younger age, many are due to becoming infected after age 50. (2)</p> <p>The CDC reports that in 1998 there were 37,002 person 55 years and older with AIDS in the U.S. This number increased in 1999 to 40,017, then increased again to 42, 985 in 2000 and to 45,903 in 2001. (3)</p> <p>Of the people age 50 and over with AIDS, 52% are Blacks/African Americans or Latinos. Of the men age 50 and over with AIDS, 49% are Black/African American or Latino. Of the women age 50 and over with AIDS, 70% are Black/African American or Latino. The number of HIV/AIDS cases continues to rise in communities of color. (3)</p> <p>Heterosexual transmission of HIV is steadily increasing in persons more than 50 years of age. (2)</p> <p>Elevated levels of depression among older adults are associated with HIV increasing risk behavior and older adults are often embarrassed to talk about sex. Older people may mistake AIDS symptoms for the aches and pains of normal aging, so they are less likely than younger people to get tested for HIV. (2)</p> <p>Assumptions that sexual activity and drug use are not prevalent among older persons and that older people do not engage in sex or use drugs result in primary care physicians who do not routinely perform thorough sex and drug use risk assessments with their older patients. (4)</p> <p>Women comprise a greater percentage of all AIDS cases as age increases. Normal aging changes, such as a decrease in vaginal lubrication and thinning vaginal walls, can put older women at higher risk for HIV infection during intercourse. (5)</p> <p><b><u>Riskiness of Behavior:</u></b> The CDC has estimated that the risk of insertive vaginal sex is 10 times riskier than receiving oral sex (ROS) and that</p>

Population	Older Adults (50 years and older)
<p><b>Challenges and Obstacles to Prevention (Difficulty Meeting need)</b></p>	<p>insertive anal sex is 13 times riskier than ROS. Unprotected insertive anal sex is 13 times higher than receiving oral sex (ROS), unprotected receptive anal sex is 100 times riskier than ROS, and the risk of performing unprotected oral sex is two times higher than ROS.</p> <p><b>Prevalence of Risk Behavior:</b> The prevalence of risk behavior in the District is unknown. The San Francisco Prevention Planning Group has estimated that heterosexual women engage in unprotected receptive vaginal intercourse 77 a year, unprotected receptive anal intercourse 6 times a year, and giving fellatio, unprotected, 48 times a year.</p> <p>The San Francisco Prevention Planning Group also estimated that heterosexual men engage in unprotected insertive vaginal intercourse 82 times a year, unprotected insertive anal intercourse 6 times a year. They receive fellatio, unprotected, 42 times a year and they give cunilingus, unprotected, 41 times a year.</p> <p>A great deal of stigma attached to HIV/AIDS, homosexuality, substance abuse and open discussion about sex still exists among this population.</p> <p>The aging processes and other maturity factors require services that are age-appropriate as well as culturally competent. Generational issues need to be considered in crafting HIV prevention efforts. Older adults may not be comfortable disclosing their sexual behavior or drug use to others. This can make it difficult to find older adults who attend support groups.</p> <p><b>DC-Specific Community Consultation Findings</b></p> <p>La Clínica del Pueblo is seeing younger men involved with older women and often their daughters. Many of these older women, who are newly infected with HIV, have had tubal ligations. Most are at an age where they might have lost their husband in war or the family dissolved with immigration. Relationships with younger men are often kept secret from, or are not approved of by the adult children and result in isolation for the older woman. The younger men they are involved with tend to have multiple sex partners and engage in unprotected sex. The older women are not targeted by prevention messages and are not receiving outreach and information. (7)</p> <p>Separating the effects of normal aging from the particular experiences of growing older with HIV is a significant need. Along with feeling they are not at risk for HIV, older adults may feel marginalized from various services including HIV, educational or overall aging services. Efforts must include tailored education and treatment adherence motivation for older adults and must address extended life issues among older adults affected by HIV/AIDS.</p> <p><b>Resources and Gaps</b></p> <p>The Resource Inventory identified four HIV prevention programs that serve this population. Collectively, these organizations have a target capacity of reaching some 7,701 individuals in 2002, about 4% of this population.</p>

Population	Older Adults (50 years and older)
	<p>There is a great need for better Public Service Announcements and media campaigns featuring older adults, and few prevention efforts exist that target adults over 50. Clinicians and service providers for older adults, including caretakers and nursing home staff, need to be educated on HIV risk behaviors and symptoms of HIV infection among older adults. Clinicians need to conduct thorough sex and drug use risk assessments with their patients over 50, and challenge any assumptions that older people do not engage in these activities or will not discuss them. (5)</p>
<b>Need for Additional Studies</b>	<p>More research on sexual and drug using behavior of older adults is needed. (5)</p>
<b>Sources of Data</b>	<ol style="list-style-type: none"> <li>1. HIV Impact. HIV Among Older Persons. March/April 2002.</li> <li>2. HIV/AIDS and Older Americans. National Aging Information Center. Administration on Aging.</li> <li>3. Centers for Disease Control and Prevention.</li> <li>4. National Institute on Aging</li> <li>5. Center for AIDS Prevention Studies at the University of California San Francisco, (1997).</li> <li>6. Linsk N, Nazon M, Witten T, Baker L, Fowler JP, Rydwells B, Nokes K, Delgado V, Weinberg J. Int Conf AIDS. 1998;12:166)</li> <li>7. District of Columbia HIV Prevention Community Planning Group. Community Consultation: Immigrants. April 30, 2002.</li> </ol>

Population	People Living With HIV/AIDS
<b>Size of Population</b>	<p>19,418 – 21,418 (an estimated 12,000 to 14,000 living with HIV and 7,418 living with AIDS)</p> <p>Source: 2002 Epidemiologic Profile of the District of Columbia</p>
<b>AIDS Incidence: 1996-2001</b>	<p>An estimated 19,418 to 21,418 residents of the District are living with HIV, including 7,418 that are living with AIDS. (1) This represents between 3.4% and 3.7% of the population, or approximately 1 of each 27 to 30 residents of the District.</p> <p>A survey of state HIV/AIDS coordinators in 40 cities in the U.S. found that the District ranked 1<sup>st</sup> in AIDS incidence in 2000, with 132 cases per 100,000 population for the 2-year period ending June 30, 2000. (1)</p>
<b>Risk Assessment</b>	<p>The advent of therapies has improved the health of many people with HIV. Among some individuals, this has resulted in a reduced concern about HIV and has stimulated an increase in risk behavior. In one study, 33% of respondents believed that AIDS was a less serious threat and 15% of individuals surveyed believed that HIV therapies reduced the risk of HIV transmission. (2)</p> <p>One in three HIV-positive people engage in unprotected sex after learning they are HIV positive. (3)</p> <p><b><i>In the District of Columbia</i></b></p> <p>Among the participants in a recent survey of Black men in the District, men who were HIV-positive said they were still engaging in unprotected sex with multiple partners after being informed of their HIV status. (4)</p> <p>Of the HIV-positive respondents – 15% of the sample of 3,600 men – more than half reported having sex with two or more partners in the last 30 days. Nearly three out of 10 reported having had sex with both men and women in the last 30 days. Slightly more than half reported consistently using condoms when engaging in vaginal sex. Less than half (40%) reported consistent use of condoms during anal sex.</p> <p>In a recent study of white MSM in the District, more than two-thirds of the 86 HIV-positive respondents who were involved in ongoing sexual relationships, only 49% said they use condoms always and 18% said they used condoms only half of the time as the receptive partner during anal sex. Only 64% said they always used condoms as the insertive partner, and another 13% said they did so more than half of the time.</p> <p>Condom use during oral sex was especially low: 84% of respondents said they never (77%) or seldom (7%) used condoms when they were the receivers of oral sex and 95% of respondents reported they never (85%) or seldom (10%) used condoms when performing oral sex on their partners. (5)</p>



Population	People Living With HIV/AIDS
	<p>Of the 86 HIV-positive respondents, 85% reported involvement in casual sexual relationships over the past 12 months. Only 43% of these men said they used condoms always and 28% said they used condoms “more than half of the time” during anal sex as the receptive partner. Forty-six said they used condoms always and 29% said they used condoms more than half the time as the insertive partner. These men report they never (78%) or seldom (13%) used condoms when they were receivers of oral sex, and 93% indicated that they never (75%) or seldom (18%) used condoms when performing oral sex on their partners. (5)</p> <p>The CDC has announced an expanded approach to HIV prevention that involves extensive prevention outreach and services to those living with the disease. Every new HIV infection is the result of a seropositive individual inadvertently transmitting the virus and the CDC believes that those who are unaware of their HIV status — and consequently not receiving prevention and care services — are contributing significantly to new HIV infections.</p> <p>Because of treatment advances, more people with HIV infection are living longer and better lives. Services and interventions for high-risk negative persons may not address the needs of the HIV infected. The goals of SAFE (Serostatus Approach to Fighting the Epidemic) are now included throughout CDC’s HIV Prevention Strategic Plan.</p> <p>SAFE initially focuses on expanding voluntary counseling and testing programs to reach all individuals living with HIV infection, including those who are infected with HIV, but don’t yet know it.</p> <p>The following four additional SAFE action steps target individuals who test positive for HIV:</p> <ul style="list-style-type: none"> <li>• Increasing the number of infected individuals who are referred to, and continue to utilize, care and treatment services.</li> <li>• Facilitating quality care and treatment by linking infected individuals to care, continually updating relevant guidelines and monitoring the quality and utilization of care [Health Resources and Services Administration (HRSA) is the lead federal agency for HIV treatment].</li> <li>• Helping those living with HIV improve adherence to treatment regimens.</li> <li>• Supporting individuals living with HIV, and their partners, to adopt and sustain life-long HIV and STD risk reduction behaviors.</li> </ul> <p>Seven agencies funded by AIDS Partnership California (APC) conducted formative research on what HIV-positive people of color want and need in an HIV prevention program. The findings included:</p> <p><b>Client issues</b></p> <ul style="list-style-type: none"> <li>• Clients feel severe social isolation and face multiple stigmas of</li> </ul>

Population	People Living With HIV/AIDS
	<p>HIV/AIDS, drug use and sex work, as well as racism and homophobia.</p> <ul style="list-style-type: none"> <li>• They are concerned about infecting others and want skills training on how to disclose their HIV status to partners and negotiate safer sex.</li> <li>• Clients reported boredom, or "having nothing to do" as a reason for engaging in unsafe sex. Many are unemployed or on disability and therefore have a lot of free time.</li> </ul> <p><b>Program issues</b></p> <ul style="list-style-type: none"> <li>• Clients want services that offer an overall wellness model with a focus on staying healthy and looking good, not just HIV/AIDS-related issues.</li> <li>• Clients desire programs that aren't clinic-based and that are separate (programmatically and geographically) from treatment and care programs.</li> <li>• However, prevention services should be integrated with other HIV and drug abuse services. Staff at other services should be made aware of prevention issues and programs.</li> <li>• They want programs that offer social events to help reduce isolation, build a sense of community and meet other HIV-positive persons for friendship and dating.</li> <li>• Services need to be culturally appropriate (ethnicity, gender, language and sexual orientation), building on the uniqueness of each community.</li> <li>• Clients want more access to mental health services.</li> <li>• Providing incentives (money, coupons, transportation, dinner) helps to recognize the contributions of clients and ensure participation.</li> </ul> <p>Prevention efforts for HIV-positive persons have focused on protecting one's own health from the possibility of re-infection with untreatable strains of HIV. Few efforts have addressed altruism – the responsibility of HIV-positive persons to not transmit the virus to others and the opportunity for HIV-positive persons to actively contribute to ending the epidemic. Prevention efforts need to address both issues: taking responsibility for one's own health and the health of one's partners, children, other family members and community. (6,7)</p> <p>Incorrect assumptions and denial of responsibility between partners can lead to risky behavior. Many HIV-negative persons are unaware of their partners' status or risk behaviors and may make assumptions that they are not at risk for HIV because they are married, in a relationship, their partner looks healthy, or simply because their partner did not ask to use a condom. HIV-positive persons may make the same assumptions that their partner is also HIV-positive because the partner didn't ask about serostatus or suggest using condoms. (8) Likewise, there may be a difference of opinion on who's responsible for keeping safe, the HIV-</p>

Population	People Living With HIV/AIDS
	<p>positive person, the HIV-negative person, or both.</p> <p>Often, the same factors that led someone to become infected are also barriers to preventing transmission. Many HIV-positive persons face complex issues that can affect their ability to engage in safer sex or drug-using behaviors. Depression, substance use and abuse, history of violence and abuse and sexual compulsivity are all issues that may need to be addressed. (7, 9) Many of these issues cannot be addressed in a prevention program and may require referral to longer-term counseling or other social services.</p> <p>In 1998, the CDC funded five Health Departments to create demonstration projects providing primary HIV prevention for HIV-positive individuals. California, Los Angeles, San Francisco, Maryland and Wisconsin have begun a variety of programs that address a wide audience including: HIV-positive women, men of color who have sex with men, IDUs, youth, female sex and needle sharing partners of IDUs, and incarcerated men and women. Interventions include: HIV, STD and TB counseling, testing and treatment; referral and linkage to care; prevention case management; HIV-positive peer "buddies"; outreach via social networks; mass media and internet marketing; partner counseling and referral services; skills-building; and community-level forums and social events. (9)</p> <p>Couples counseling for serodiscordant couples (where one partner is HIV-positive and the other HIV-negative) has proven highly effective at reducing new HIV infections. One program for heterosexual women and men provided couples counseling in combination with social support. As a result, condom use increased and no new HIV infections were reported among the couples. (10)</p> <p>HIV prevention programs need to address HIV-positive persons and include STD, hepatitis and TB screening and treatment as well as referrals to drug treatment, family planning and mental health services. HIV-positive persons' partners, children and families must be included with support and education. ( 11)</p>
<b>Resources and Gaps</b>	<p>The Resource Inventory found that three organizations target this population. They expect to reach 1,151 individuals in 2002.</p>
<b>Sources of Data</b>	<ol style="list-style-type: none"> <li>1. HIV/AIDS Administration, Epidemiologic Profile of the District of Columbia, 2002.</li> <li>2. Demmer C. Impact of improved treatments on perceptions about HIV and safer sex among inner-city HIV-infected men and women. J Community Health 2002 Feb;27(1):63-73.</li> <li>3. Kalichman SC, Rompa D, Cage M, DiFonzo K, Simpson D, Austin J, Luke W, Buckles J, Kyomugisha F, Benotsch E, Pinkerton S, Graham J. Effectiveness of an intervention to reduce HIV transmission risks in HIV-positive people. Am J Prev Med 2001 Aug;21(2):84-92.</li> <li>4. Regional Addiction Prevention Inc and Health Evaluation Research Services Male Sexual Health Survey. 2000. Washington, DC.</li> </ol>

Population	People Living With HIV/AIDS
	<ol style="list-style-type: none"> <li>5. Whitman Walker Clinic, District of Columbia Department of Health HIV/AIDS Administration. Men who have sex with men (MSM) Survey Results 2001. January 10, 2002</li> <li>6. Marks G, Burris S, Peterman TA. Reducing sexual transmission of HIV from those who know they are infected: the need for personal and collective responsibility (editorial). AIDS. 1999;13:297-306.</li> <li>7. 5. Wolitsky R, Seropositive Urban Men's Study Group. Rethinking primary prevention to meet the needs of gay and bisexual men living with HIV. Presented at the National HIV Prevention Conference, Atlanta, GA. August 31, 1999. Abst. #184.</li> <li>8. 7. Hays RB, Paul J, Ekstrand M, et al. Actual versus perceived HIV status, sexual behaviors and predictors of unprotected sex among young gay and bisexual men who identify as HIV-negative, HIV-positive and untested. AIDS. 1997;11:1495-1502.</li> <li>9. 13. Senterfitt WR. Presented at the Annual Meeting of the National Alliance of State and Territorial AIDS Directors. 2000.</li> <li>10. 15. Padian NS, O'Brien YR, Chang Y, et al. Prevention of heterosexual transmission of human immunodeficiency virus through couple counseling. Journal of Acquired Immune Deficiency Syndrome. 1993;6:1043-1048.</li> <li>11. What Are HIV-positive Persons' HIV Prevention Needs? Center for AIDS Prevention Studies, at the University of San Francisco, 1999.</li> </ol>

Population	Pregnant Women with or at risk for HIV (Perinatal transmission)
<b>Size of Population</b>	<p>10,679</p> <p>Estimate based on a report from the District's State Center for Health Statistics on the number of pregnancies in the District in 1998</p>
<b>AIDS Incidence: 1996-2001</b>	<b>Unknown</b>
<b>Risk Assessment</b>	<p>Between 1980 and 2001 there were 172 cases of pediatric AIDS (children 0 to 12 years old), which was 1.2% of all AIDS cases in the District. For the period 1996-2001, there were 37 new cases of pediatric AIDS in the District. They represented 0.8% of all AIDS cases. (1)</p> <p>Of the children born to 97 HIV-positive women in the District in 1999, five were HIV-positive. In 2000, five or fewer children born to 78 HIV-positive women in 2000 were HIV-positive.</p> <p>Nationally, 196 cases of AIDS were reported among children less than 13 years of age in 2000 in the United States, a decrease from 263 in 1999. Nearly all the recent AIDS cases reported in children were acquired through mother-to-child, or perinatal transmission. Reasons for the decrease include the increasing use of antiretroviral therapies, decreases in the number of HIV-infected women giving birth, and improvements in the clinical management of women and children. (2)</p> <p>The goal of providing optimal care for HIV infected pregnant patients in labor is often hampered by the lack of an HIV diagnosis at presentation. Women may not have been tested during prenatal care, may have been infected later in pregnancy after the test was performed, or may not have received prenatal care. (3)</p> <p>With increasing numbers of HIV infected women, 80% of whom are of childbearing age, and concerns about perinatal transmission of HIV, pregnancy in the setting of HIV infection has been a focus of much interest, research, and often discrimination. (4)</p> <p>Unprotected sex with multiple partners has been associated with increased risk for HIV infection. More than half of pregnancies in U.S. women are unplanned, and many of the risk factors for unintended pregnancy also place women at increased risk for HIV. These factors include: substance abuse (patient and partner), mental illness, STD's, and domestic violence.</p> <p>There is evidence that both combined oral contraceptives and progestin-only contraceptives may increase genital tract HIV shedding. Sexually transmitted diseases (STDs) have been shown to increase genital tract HIV shedding, which may increase risk for perinatal transmission.</p> <p>Cigarette smoking and illicit drug use has been associated with an increased risk of perinatal transmission.</p> <p>Mothers who seroconvert to HIV-positive status after delivery and while</p>

<b>Population</b>	<b>Pregnant Women with or at risk for HIV (Perinatal transmission)</b>
	breastfeeding appear to have a higher risk of transmission than women who seroconverted prior to delivery (5)
<b>Recurring and Emerging Issues</b>	A lack of prenatal care has been a long-standing problem in certain population subgroups. (2)
<b>Resources and Gaps</b>	<p>The Resource Inventory identified three HIV prevention programs that target pregnant women and at risk women of childbearing age. They expect to reach 2,101 women in 2002.</p> <p>There is a need for more gender specific healthcare providers and agencies that specialize in HIV/AIDS treatment for women. (4)</p> <p>More services are needed to offer comprehensive HIV and pregnancy counseling to address the following issues:</p> <ul style="list-style-type: none"> <li>• Impact of HIV on pregnancy course/outcome</li> <li>• Impact of pregnancy on HIV progression</li> <li>• Other reproductive issues based on maternal factors</li> <li>• Coexisting drug/alcohol use</li> <li>• Advanced maternal age</li> <li>• Hypertension, diabetes, etc.</li> <li>• Long term health of mother and care for children (guardianship issues)</li> <li>• Perinatal transmission</li> <li>• Use of antiretrovirals and other medications during pregnancy</li> <li>• Safe conception if partner is HIV negative</li> </ul>
<b>Sources of Data</b>	<ol style="list-style-type: none"> <li>1. HIV/AIDS Administration, Epidemiologic Profile of the District of Columbia, 2002.</li> <li>2. HIV/AIDS Surveillance Report – Centers for Disease Control and Prevention Vol. 12, No 1. June 2000.</li> <li>3. Keller, J., Ross, B. &amp; Anderson, J. (2002). Update on Women and HIV. The Hopkins HIV Report.</li> <li>4. Anderson, J. (2001). A Guide to the Clinical Care of Women With HIV. U.S. Department of Health and Human Services, Health Resources and Services Administration, Perinatal and Postnatal Transmission of HIV infection: A Fact Sheet. February 1999. <a href="http://www.pedhivaids.org">www.pedhivaids.org</a></li> </ol>

<b>Population</b>	<b>Substance Users (non-IDU)</b>
<b>Size of Population</b>	<p>50,280</p> <p>Estimate from a study by the DC Department of Health, Addiction Prevention and Recovery Administration (APRA)</p>
<b>AIDS Incidence: 1996-2001</b>	<b>Unknown</b>
<b>General Characteristics of the Population</b>	<p>There are varying degrees of misuse of drugs and alcohol from the single incident of misuse to chronic misuse associated with an addictive disorder. The DC Department of Health, Addiction Prevention Recovery Administration conducted a household survey in 2000 on substance abuse and found the following: (1)</p> <ul style="list-style-type: none"> <li>• 22% of non-institutionalized persons age 12 and older experienced problems related to alcohol use in the last year. With this group, youth ages 18–24 were most likely to report symptoms of dependence on alcohol and those ages 12–17 were most likely to report dependence marijuana.</li> <li>• 4% of non-institutionalized persons age 12 and older reported at least one symptom of dependence on cocaine. Adults 25–34 were more likely to report symptoms of dependence on cocaine.</li> <li>• Except for cocaine, males were more likely than females to have experienced symptoms of dependence. Among cocaine users, 81% of females compared with 38% of males reported dependence</li> </ul>
<b>Risk Assessment</b>	<p>The linkages between sex-for-crack exchanges, commercial sex work and rising rates of HIV and other sexually transmitted diseases among cocaine-dependent women have been well documented. Though crack users report reduced desire for sex and diminished ability to have sex after smoking crack, crack use has been found to be associated with increased sexual activity, trading sex for money or drugs, and sex with multiple partners. (3) Many drug abusers who use crack find shelter in “crack houses” where continuous use of the drug, bartering with sex, unsanitary environments, and other at-risk behaviors may engage its inhabitants for days and weeks at a time. Safe-sex practices are at a minimum in these instances.</p> <p>High-risk sex behaviors have been found to be far more prevalent among cocaine users than marijuana or alcohol users. A greater number of cocaine users reported having multiple sex partners, not using condoms, and using drugs during sex. Female cocaine users showed the same risk level for HIV infection as male cocaine users. (3)</p> <p>A study in Baltimore found that short-term non-injecting drug use, particularly exclusive crack smoking, was associated with adolescent initiation of injecting drug use. Early prevention efforts targeting this high-risk group of younger drug users are warranted in order to delay or</p>

Population	Substance Users (non-IDU)
	<p>prevent onset of injecting drug use. (2)</p> <p>Another drug that is relatively new to the drug market scene, but is commonly used and favored is the drug Ecstasy. The drug is dubbed the “sex drug” as its use often enhances sexual desires and often leads to precarious drug and sex scenarios, including unprotected sex. (5)</p> <p>The most commonly used substance is alcohol and when it is abused it is a factor in HIV risk behaviors. In a study of drug use and risk behaviors among MSM, it was found that of the men who drank alcohol, those who drank more frequently before or during sex engaged in significantly more receptive anal intercourse with casual partners. Of the men who used other drugs, those who used drugs more frequently before or during sex were more also more likely to engage in receptive anal intercourse with casual partners. (4)</p> <p>Studies have found that persons who use drugs that have a greater stigma attached (i.e., crack versus alcohol) are also more likely to engage in high risk HIV behavior</p> <p>People who abuse alcohol, speed, crack cocaine, poppers or other non-injected drugs are more likely than non-substance users to be HIV-positive. People with a history of non-injecting substance abuse are also more likely to engage in high-risk sexual activities. (6)</p> <p>A survey of heterosexuals in alcohol treatment programs in San Francisco, CA, found HIV infection rates of 3% for men who were not homosexually active or IDUs, and of 4% for women who were not IDUs. This was considerably higher than rates of 0.5% for men and 0.2% for women found in a similar population survey. (7)</p> <p>Crack cocaine use has been shown to be strongly associated with the transmission of HIV. A study of young adults in three inner-city neighborhoods who smoked crack and had never injected drugs found a 15.7% HIV rate. Women who had recently had unprotected sex in exchange for money or drugs and men who had anal sex with other men were most likely to be infected. (8)</p> <p>For non-injecting substance abusers, HIV infection is not caused by drug use but by unsafe sexual behavior. Recently, observers have found an association between HIV infection, heavy crack use and unprotected fellatio among prostitutes. This may be due to poor oral hygiene and oral damage from crack pipes, high frequency of fellatio, and inconsistent condom use. (9)</p> <p>Gay male substance abusers in San Francisco, CA, identified a number of factors that made safe sex difficult for them, including: perceived disinhibiting effect of alcohol and other drugs, learned patterns of association between substance use and sex (especially methamphetamine use and anal sex), low self-esteem, lack of assertiveness, and perceived powerlessness. (10)</p> <p>It is often believed that having unprotected sex while under the influence of drugs or alcohol accounts for substance abusers' HIV risk. However,</p>



Population	Substance Users (non-IDU)
<b>Challenges and Obstacles to Prevention (Difficulty Meeting need)</b>	<p>sexual networks and sexual mixing might better explain risk. (11) Many people who are in treatment or using drugs or alcohol are primarily selecting sexual partners from similar networks. They might include people who have used needles, have traded sex for money or drugs, have been victims of trauma, or have been incarcerated. All of these populations may have higher rates of HIV infection, making transmission more likely.</p> <p>Gender specific programs are needed that address women's substance use needs. Women have a higher physical vulnerability to alcohol and higher levels of traumatic events associated with substance use than men. (12) Gay and lesbian-specific treatment is also needed. In addition, specific treatment is needed for drugs such as crack cocaine and new drugs as they arrive on the scene.</p> <p>The factors that may contribute to an individual abusing substances may also be barriers to reducing HIV risk by engaging in protective behaviors. Drug use is rarely a problem by itself. It is frequently complicated with other circumstances and personal conditions – social circumstances such as poverty and unemployment, or health conditions such as mental illness. Drug use is often used as a coping strategy to deal with the stresses that many individuals face. This complicates the underlying issues that must be addressed for any sustainable difference in risk behaviors. (4)</p>
<b>Resources and Gaps</b>	<p>The Resource Inventory identified two HIV prevention programs that target non-IDU substance users. They expect to reach 1,440 individuals in 2002.</p>
<b>Need for Additional Studies</b>	<p>There is a need for behavioral studies on the risk behaviors of individuals who use or abuse substances, and on the most appropriate interventions for these populations.</p>
<b>Sources of Data</b>	<ol style="list-style-type: none"> <li>1. DC Department of Health Addiction Prevention Recovery Administration (2001) 2000 Household Survey on Substance Abuse</li> <li>2. Fuller CM, Vlahov D, Arria AM, Ompad DC, Garfein R, Strathdee SA (2002) Factors associated with adolescent initiation of injecting drug use, Public Health Reports 116 Suppl 1:136-45</li> <li>3. Wang MQ, Collins CB, Kohler CL, DiClemente RJ, Wingood G (2000) Drug use and HIV risk--related sex behaviors: a street outreach study of black adults. Southern Medicine Journal Feb;93(2):186-90</li> <li>4. Purcell DW, Parsons JT, Halkitis PN, Mizuno Y, Woods WJ (2001) Substance use and sexual transmission risk behavior of HIV-positive men who have sex with men. J Subst Abuse 2001;13(1-2):185-200</li> <li>5. Pach,A; Brown, J; Toce, M; Henrickson, J; and Cerbone, F. (2001) Patterns and Trends of Drug Abuse in Washington, DC Proceedings of the Community Epidemiology Work Group, December 2001</li> <li>6. Leigh BC, Stall R. Substance use and risky sexual behavior for exposure to HIV. American Psychologist. 1993;48:1035-1045.</li> </ol>

Population	Substance Users (non-IDU)
	<ol style="list-style-type: none"> <li>7. Avins AL, Woods WJ, Lindan CP, et al. HIV infection and risk behaviors among heterosexuals in alcohol treatment programs. <i>Journal of the American Medical Association</i>. 1994;271:515-518.</li> <li>8. Edlin BR, Irwin KL, Faruque S, et al. Intersecting epidemics - crack cocaine use and HIV infection among inner-city young adults. <i>New England Journal of Medicine</i>. 1994;331:1422-1427.</li> <li>9. Wallace JI, Bloch D, Whitmore R, et al. Fellatio is a significant risk activity for acquiring AIDS in New York City street walking sex workers. Presented at the Eleventh International Conference on AIDS, Vancouver BC; 1996. Abs #Tu.C.2673.</li> <li>10. Paul JP, Stall R, Davis F. Sexual risk for HIV transmission among gay/bisexual men in substance-abuse treatment. <i>AIDS Education and Prevention</i>. 1993;5:11-24.</li> <li>11. Renton A, Whitaker L, Ison C, et al. Estimating the sexual mixing patterns in the general population from those in people acquiring gonorrhea infection: theoretical foundation and empirical findings. <i>Journal of Epidemiology and Community Health</i>. 1995;49:205-213.</li> <li>12. 12. el-Guebaly N. Alcohol and polysubstance abuse among women. <i>Canadian Journal of Psychiatry</i>. 1995;40:73-79.</li> </ol>

<b>Population</b>	<b>Transgendered Persons</b>
<b>Size of Population</b>	<b>Unknown</b>
<b>AIDS Incidence: 1996-2001</b>	<b>Unknown</b>
<b>General Characteristics of the Population</b>	<p>Transgender is an umbrella term used to describe persons who cannot or choose not to conform to societal gender norms associated with their physical sex. (1) Such individuals have gender identities, expressions or behaviors not traditionally associated with their birth sex. Transgender persons live their lives to varying degrees as their chosen gender and may self-identify as female, male, trans-women or -men, non-operative transsexuals, pre-operative transsexuals, transsexuals who have completed surgical sex reassignment, transvestites or cross-dressers, among others. These terms vary regionally and over time.</p>
<b>Risk Assessment</b>	<p>Male to female transgender persons (MTFs) have high rates of HIV infection, with overall rates of 35% in San Francisco in 1997 and 22% in Los Angeles in 1998. (2, 3) A study of MTF sex workers in Atlanta found that 68% tested positive for HIV. (4) Infections among MTFs continue to rise, with an estimated rate of new infections of 3-8% per year. (3, 5) African American MTFs have higher rates of HIV than other racial/ethnic groups.(2-5)</p> <p>In the District, 25% of 252 participants in a study on the transgender population – both male to female and female to male – reported that they were HIV-positive. The rate was even higher (32%) for MTFs. Twenty-two percent did not know their HIV status. (6)</p> <p>Of those who reported they were HIV-positive, two-thirds said they believed that they became infected with HIV through unprotected sex with a non-transgender male. Of the sample of 252 individuals, 75% reported being born anatomically male, 24% were born anatomically female and 1% intersexed</p> <p>The highest rates for risk behavior on a lifetime basis was unprotected oral sex (77%) and unprotected genital-anal contact. The top three reasons participants gave for engaging in unsafe practices were that they trusted their sex partners (41%), that their partners “appeared” to be healthy (36%), and that they didn’t know there was a risk associated with the behavior (25%). (6)</p> <p>The majority of the participants in the study, which was completed in 2000, reported their sexual orientation as gay (65%), their gender identity as transgender (69%) and their relationship status as single (69%).</p> <p>Fifty two percent of the participants in the DC study said they had taken hormones at some point in their lives, and 36% reported that they were currently doing so. Fifty eight percent said they acquired hormones from friends or on the street.</p>

Population	Transgendered Persons
<b>Challenges and Obstacles to Prevention (Difficulty Meeting need)</b>	<p>MTFs may inject female hormones in order to feminize their bodies. HIV risk through hormone injection varies regionally, with New York reporting more risk than in San Francisco, due to differences in availability of hormones and hormone syringes. (2,7) In San Francisco, the needle exchange programs offers hormone syringes and a number of public health clinics offer free or low-cost hormone therapy.</p> <p>Transphobia, or the pervasive social stigmatization of MTFs, greatly exacerbates their HIV risk. This intense stigmatization results in their social marginalization, which includes the denial of educational, employment and housing opportunities. (8,9) It also creates multiple barriers to accessing health care. Such marginalization lowers MTFs' self esteem, increases the likelihood of survival sex work and lessens the likelihood of safer sex practices. (10) All of this leads to high rates of HIV, STDs, drug use and attempted suicide.</p> <p>MTFs primarily have sex with men and are likely to engage in receptive anal sex, which puts them at increased risk. (2,3,11) Some MTF sex workers are willing to not use condoms with their paying partners if they are offered more money. (9) However, some studies show that most unprotected sex occurs with primary partners, not paying partners. (3)</p> <p>For many MTFs, securing employment and housing are more pressing issues than HIV and must be addressed before HIV prevention efforts can be effective. (12)</p> <p>The District study concluded that, “The transgender population is radically different from MSM communities, due to such factors as the negative impact of... discrimination and violence on educational, employment and housing opportunities; the negative impact of transphobia and trans-ignorance on health care access; the urgent need of transgendered people for access to transgender care; and the impact of gender identity issues on education and prevention.”</p> <p>Lack of or limited education, homelessness, and unemployment have had a tremendous impact upon the influence of behavioral and attitude risks among this population. Studies have reported an unemployment rate of 42% for this population in Washington, D.C. These circumstances often force transgendered persons to live an “underground” lifestyle as a means of survival. (6)</p>
	<p>The sexual practices of transgendered persons are not widely explored. Due to discrimination, violence and stigmatization, transgendered persons seem to be reluctant to disclose information regarding their sexual practices. (6)</p> <p>Another challenge faced by this population is the lack of culturally competent and appropriate transgendered health facilities and providers. Many healthcare providers are not trained to address the needs of transgendered persons. Many transgendered persons have stated that they have experienced insensitivity and hostility while attempting to seek medical care. Quality healthcare standards and practices are a must to</p>

<b>Population</b>	<b>Transgendered Persons</b>
	<p>properly treat the needs and educate the community. (6)</p> <p>There is a great challenge to create and disseminate prevention materials specifically targeted to transgendered persons.</p> <p>Socioeconomic factors such as lack of insurance, unemployment and homelessness have played a role in deterring persons from obtaining HIV prevention and intervention services. Those transgendered persons who choose to live openly often endure employment, housing, and medical discrimination. All too often, the service needs for transgendered persons have been lumped in with the same category as services for MSM populations. (6)</p>
<b>Resources and Gaps</b>	The Resource Inventory identified five HIV prevention programs that target this population. They expect to reach 3,039 individuals in 2002.
<b>Need for Additional Studies</b>	Due to the lack of extensive and comprehensive research, many questions and concerns continue to go unanswered in the quest to address the needs of the transgendered population. There is a need for additional behavioral studies on the risk behaviors and on the most appropriate HIV interventions for this population.
<b>Sources of Data</b>	<ol style="list-style-type: none"> <li>1. Gender Education and Advocacy. Gender Variance: A Primer. 2001. <a href="http://www.gender.org/resources/dge/gea01004.pdf">www.gender.org/resources/dge/gea01004.pdf</a></li> <li>2. Clements-Nolle K, Marx R, Guzman R, et al. HIV prevalence, risk behaviors, health care use, and mental health status of transgender persons in San Francisco: Implications for public health intervention. American Journal of Public Health. 2001;91:915-921.</li> <li>3. Simon PA, Reback CJ, Bemis CC. HIV prevalence and incidence among male-to-female transsexuals receiving HIV prevention services in Los Angeles County (letter). AIDS. 2000;14: 2953-2955.</li> <li>4. Elifson KW, Boles J, Posey E, et al. Male transvestite prostitutes and HIV risk. American Journal of Public Health. 1993;83:260-262.</li> <li>5. Kellogg TA, Clements-Nolle K, McFarland W, et al. Incidence of Human Immunodeficiency Virus (HIV) among male-to-female transgendered persons in San Francisco. Journal of the Acquired Immune Deficiency Syndromes. in press.</li> <li>6. Xavier, J.M. (2000). Final Report for Phase Two, The Washington Transgendered Needs Assessment Survey. Us Helping Us, Washington, DC.</li> <li>7. McGowan CK. Transgender needs assessment. the HIV Prevention Planning Unit of the New York City Department of Health. December 1999.</li> <li>8. Green J. Investigation into Discrimination against Transgendered People: A Report by the Human Rights Commission, City and County of San Francisco. 1994;1:8-10 &amp; 43-52.</li> <li>9. Nemoto T, Luke, D, Mamo L, et al. HIV risk behaviors among male-to-female transgenders in comparison with homosexual or bisexual males and</li> </ol>

Population	Transgendered Persons
	<p>heterosexual females. AIDS Care.1999;11:297-312.</p> <p>10. Bockting WO, Robinson BE, Rosser BR. Transgender HIV prevention: a qualitative needs assessment. AIDS Care. 1998;10:505-525.</p> <p>11. Boles J, Elifson KW. The social organization of transvestite prostitution and AIDS. Social Science and Medicine. 1994;39:85-93.</p> <p>12. Clements-Nolle K, Wilkinson W, Kitano K. HIV Prevention and Health Service Needs of the Transgender Community in San Francisco. in W. Bockting &amp; S Kirk editors: Transgender and HIV: Risks, prevention and care. Binghamton, NY: The Haworth Press, Inc. 2001; in press</p>